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No.

# In the Supreme Court of the United States

OCTOBER TERM, 1979

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PATRICIA R. HARRIS, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

*v.*

NONNIE MAE NORMAN, ET AL.

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## PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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### QUESTION PRESENTED

Whether the Medicaid statute prohibits participating states from adopting fixed standards, pursuant to a regulation of the Secretary of Health and Human Services, for determining what part of the income of the spouse of a Medicaid applicant is "available" to the applicant for the purpose of evaluating the applicant's eligibility for Medicaid assistance and, if eligible, the extent of assistance.

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* Other plaintiffs in the proceedings below were (1) all married persons in the State of Mississippi (a) who are separated from their spouses, (b) who are receiving no support from their spouses, whose spouses are over 65 years of age, blind, or permanently and totally physically or mentally disabled, and (c) who would be eligible for Medicaid assistance except for the income or resources of their spouses; (2) all married persons in the State of Mississippi (a) who live with their spouses, (b) who are receiving some support from their spouses, (c) who are over 65 years of age, blind, or permanently and totally physically or mentally disabled, and (d) who would be eligible for Medicaid assistance except for the income of their spouses; (3) all married persons in the State of Mississippi; (a) whose spouses are over 65 years of age, blind or permanently and totally physically or mentally disabled and (b) who received Social Security benefits pursuant to the OASDI program.

Other defendants in the proceedings below were the Commissioner of the Mississippi State Department of Public Welfare, the Director of the Mississippi Medicaid Commission, the members of the State Board of the Mississippi State Department of Public Welfare, and the members of the Mississippi Medicaid Commission.

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The Solicitor General, on behalf of the Secretary of Health and Human Services, petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

## OPINIONS BELOW

The opinion of the court of appeals (App. A, *infra*, 1a-30a) is reported at 610 F.2d 1228. The order of the district court (App. D, *infra*, 34a), adopting the opinion (App. F, *infra*, 36a-44a) and judgment (App. G, *infra*, 45a-46a) of the magistrate to whom the case was referred, is not reported. The order of the district court (App. E, *infra*, 35a), adopting the opinion of the magistrate, as amended (App. H, *infra*, 47a-48a), is not reported.

## JURISDICTION

The judgment of the court of appeals (App. B, *infra*, 31a) was entered on January 28, 1980, and a petition for rehearing was denied on April 30, 1980 (App. C, *infra*, 32a-33a). On July 16, 1980, Mr. Justice Powell extended the time for filing a petition for a writ of certiorari to and including September 27, 1980 (App. J, *infra*, 51a). The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

## STATUTORY PROVISIONS INVOLVED

1. 42 U.S.C. 1396a(a) provides in pertinent part:

A state plan for medical assistance must —

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, based on the variations between shelter

costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient * * * in determining his eligibility for such aid, assistance or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

2. 42 U.S.C. 1396a(f) provides in pertinent part:

Notwithstanding any other provision of this subchapter, * * * no State not eligible to participate in the State plan program established under subchapter XVI of this chapter shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of subchapter XVI of this chapter) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under

the State plan) the income of any such individual as determined in accordance with section 1396b(f) of this title (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972.

## STATEMENT

1. The Medicaid program was established in Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, "for the purpose of providing federal financial assistance to states that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae*, No. 79–1268 (June 30, 1980), slip op. 1–2. As adopted in 1965, Title XIX required participating states to provide medical assistance to individuals who received cash assistance under any of the four "categorically needy" assistance programs established in the Social Security Act.[1] Under Section 1902(a)(17) of the Act, 42 U.S.C. 1396a(a)(17), each participating state was required to adopt "reasonable standards * * * for determining eligibility for and the extent of medical assistance," taking into account "only such income and resources as are * * * available to the applicant or recipient." Furthermore, in response to practices that had been used by states in administering the medical assistance plans established under the Kerr-Mills program, Congress required participating states to refrain from taking into account "the financial responsibility of any individual for any applicant or recipient of assistance * * * *unless such applicant or recipient is such individual's*

[1] Old Age Assistance (OAA), Title I, 42 U.S.C. (1970 ed.) 301 *et seq.*; Aid to Families with Dependent Children (AFDC), Title IV, 42 U.S.C. (1970 ed.) 601 *et seq.*; Aid to the Blind (AB), Title X, 42 U.S.C. (1970 ed.) 1201 *et seq.*; Aid to the Permanently and Totally Disabled (APTD), Title XIV, 42 U.S.C. (1970 ed.) 1351 *et seq.* Participating states could offer medical assistance to individuals whose income was greater than permissible under the categorical assistance plans but inadequate to

*spouse*" or minor, blind, or disabled child. 42 U.S.C. 1396a(a)(17)(D).

With the approval of the Secretary of Health, Education, and Welfare (now Health and Human Services), some states took the position that it was reasonable to expect an applicant's spouse to help pay the cost of the applicant's medical expenses and, therefore, adopted rules that took into account the income of the spouse in determining Medicaid eligibility and the amount of assistance. These states calculated an amount considered necessary to pay the basic living expenses of the applicant's spouse and "deemed" any income of the spouse in excess of that amount as "available" to the applicant. In accordance with Congress' expressed intent that the medical expenses of the "most needy" be met first under the Medicaid program,[2] the amount considered necessary to pay the basic living expenses of the applicant's spouse was set near subsistence level.

In 1972, Congress replaced three of the four categorical assistance programs with a new federal program, Supplemental Security Income for the Aged, Blind, and Disabled (SSI), Title XVI, 42 U.S.C. 1381 *et seq.*[3] From the beginning of the Medicaid program in 1965, participating states were required to provide medical assistance to those individuals receiving benefits under their categorical assistance programs. Adoption of the SSI program was not intended to affect this traditional linkage. But under the SSI program, the states would no longer control the standards of need for the aged, blind, or disabled. The group of individuals who would be eligible for SSI assistance, and therefore eligible for Medicaid assistance, was in some cases significantly larger than the group that was eligible

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pay medical expenses, but Congress thought it appropriate that the medical expenses of the "most needy" be met before extending benefits to the less needy. See, *e.g.*, S. Rep. No. 404, 89th Cong., 1st Sess. 77 (1965).

[2]See, *e.g.*, S. Rep. No. 404, 89th Cong. 1st Sess. 77, 78–79 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess. 66, 68 (1965).

[3]As its name indicates, the SSI program replaced the categorical assistance plans for the aged, blind, and disabled.

under the prior assistance programs for the aged, blind, and disabled. To avoid forcing the states that participated in the Medicaid program to choose among (1) expanding their Medicaid assistance obligations involuntarily, (2) withdrawing from the Medicaid program, or (3) reducing the level of benefits provided under the Medicaid program, Congress offered the states what has come to be called the "209(b) option," 42 U.S.C. 1396a(f).[4] Each state was given the choice of providing medical assistance to all recipients of cash assistance under the SSI program or to the more limited group of individuals who would have been eligible for assistance under the state's Medicaid plan on January 1, 1972.

Under the SSI statute, the income of an applicant's spouse is attributed to the applicant for the purpose of determining eligibility and the amount of assistance.[5] Any state that participates in the Medicaid program but fails to exercise the 209(b) option (an "SSI state") is required to provide medical assistance to all SSI benefit recipients. To avoid the unfairness and administrative difficulties involved in permitting individual SSI states to determine Medicaid eligibility by reference to rules different from those applied in determining SSI eligibility, the Secretary issued regulations requiring SSI states, in making Medicaid determinations, to consider the income of an applicant's spouse only to the extent required by the SSI statute. 42 C.F.R. 435.723.[6]

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[4]The provision was enacted as Section 209(b) of the Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1381.

[5]When the applicant and his spouse live in the same household the income of both is considered in determining the eligibility of either for SSI benefits. 42 U.S.C. 1382(a)(2), 1382c(b), (f)(1). When the applicant and his spouse cease to share the same household, the income of the applicant's spouse is no longer considered in determining the applicant's eligibility for SSI benefits, unless the applicant's spouse is an "eligible spouse," as defined in 42 U.S.C. 1382c(b). Because of the definition of "eligible spouse," no one can remain an "eligible spouse" for more than six months after separation from his spouse. 42 U.S.C. 1382c(b).

[6]For example, without such regulations, if an applicant becomes eligible for and receives SSI benefits because his noneligible spouse no

In addition, the Secretary required 209(b) states to consider the income of an applicant's spouse in determining Medicaid eligibility and level of benefits at least to the extent that it would be considered in a SSI state.[7] 42 C.F.R. 435.734. Section 209(b) of the 1972 amendments, 42 U.S.C. 1396a(f), however, authorizes the states that exercise the option to apply the eligibility standards of their Medicaid programs that were in effect in January 1972. Therefore, the Secretary determined that it would be appropriate to allow Section 209(b) states to consider the income of an applicant's spouse to the extent they would have done so under their 1972 Medicaid plans. 42 C.F.R. 435.734.

2. Plaintiffs, on behalf of themselves and others similarly situated, brought suit in the United States District Court for the Southern District of Mississippi to challenge the Medicaid deeming practices of Mississippi, a 209(b) state, as inconsistent with the requirements of Section 1902(a)(17) of the Social Security Act, 42 U.S.C. 1396a(a)(17).[8] Initially, the district court concluded that any consideration of the income of an applicant's spouse based on an "arbitrary formula" and not related to the "actual expenditures" of the spouse was inconsistent with the dictates of Section 1902(a)(17) (App. F, *infra*, 44a; App. D, *infra*, 34a). In light of "the difficulty inherent in de-

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longer lives in his home and therefore her income is not attributed to him, he is eligible for Medicaid benefits in an SSI state even if he would not qualify under the state Medicaid rules because the income of his spouse is still considered. But if the same individual is unwilling to accept SSI benefits and applies directly to the state Medicaid agency he will be denied assistance. This discrimination between needy individuals and equally needy individuals who, for their own reasons, are unwilling to accept SSI benefits clearly was not intended by Congress.

[7] If, in SSI states, the term "available" income, as used in 42 U.S.C. 1396a(a)(17), now included the income of an applicant's spouse to the extent required in the SSI statute, the Secretary reasoned that the term should be interpreted in the same manner in 209(b) states.

[8] Plaintiffs also raised several other statutory claims and argued that "deeming" constituted an "irrebuttable presumption," violating the Due Process Clause of the Fourteenth Amendment. The court of appeals properly rejected each of these arguments (App. A, *infra*, 26a–30a).

termining the exact amount of income in fact available when spouses are living together" (App. H, *infra*, 47a; App. E., *infra*, 35a), the court later modified its judgment to permit the use of a formula for determining the amount of money necessary for the spouse to live in the community and the consideration of all income in excess of that amount as "available" to the applicant. The court ruled, however, that Mississippi could not simply rely on the "standard" established in its 1972 plan, but must calculate the amount necessary for the spouse to live in the community on the basis of "reasonable and realistic" estimates of the costs of food, clothing, shelter, medical care, and such other expenses as the state determines to be necessary (App. H, *infra*, 47a–48a; App. E, *infra*, 35a).

The court of appeals affirmed in part and reversed in part. The court of appeals overturned that portion of the district court's judgment which invalidated the practice of "deeming," stating that "income deemed from a spouse" was intended to "be a part of the 'available' income which the state may consider in determining eligibility" (App. A, *infra*, 17a). Nevertheless, the court of appeals found that because Section 1902(a)(17) refers to "flexibility" and requires participating states to adopt standards for the reasonable evaluation of the income and resources of Medicaid applicants, Mississippi could not establish and maintain a fixed standard for evaluating the amount necessary for an applicant's spouse to live in the community; "guidelines" were permissible, but a standard deduction was not (App. A, *infra*, 26a). Furthermore, the court of appeals appears to have held that Mississippi could not use the standard established in its 1972 plan, unless that standard reflected "reasonable and realistic" estimates of the costs of food, clothing, shelter, and other things reasonably necessary to the fulfillment of the spouse's basic living needs (*id.* at 25a–26a).

## REASONS FOR GRANTING THE PETITION

1. Deeming under the Medicaid Act in general, and deeming in "209(b) states" in particular, has been the subject of numerous court challenges. The court of ap-

peals' decision in this case is one of four recent circuit court decisions that have addressed the issues raised by deeming practices under the Act. See *Gray Panthers* v. *Administrator, Health Care Financing Administration, Dep't of HHS*, No. 79-1334 (D.C. Cir. July 19, 1980); *Brown* v. *Stanton*, 617 F.2d 1224 (7th Cir. 1980), pending on petition for cert., No. 79-1690; *Herweg* v. *Ray*, 619 F.2d 1265 (8th Cir. 1980), pending on petition for cert., No. 80-60. Each of these decisions is in some manner irreconcilable with the others.

In *Gray Panthers* v. *Administrator*, the D.C. Circuit found that the legislative history of the Medicaid statute "establishes a broad principle, or expectation, that 'deeming' is appropriate between spouses and from parents to children." Slip op. 11. Nevertheless, noting that the legislative history also suggested exceptions to the general rule, the court invalidated the Secretary's regulations applicable in 209(b) jurisdictions. According to the court, in issuing the regulations the Secretary failed to consider several "relevant" factors and "policy concerns." Slip op. 14.

In *Brown* v. *Stanton supra*, the Seventh Circuit effectively prohibited Indiana, a 209(b) state, from considering any of the income of an applicant's spouse "available" to an institutionalized applicant, unless the spouse actually pays the money to the institution. The court of appeals first sustained the district court's holding that in determining what part of the income of the applicant's spouse is available to the applicant, the state must make a factual determination in each case. Only if the applicant's spouse fails to establish that all of his income is needed to satisfy his "individual obligations and particular needs" can Indiana consider any of his income "available" to the applicant. But, according to the Seventh Circuit, even if Indiana makes the requisite factual findings and concludes that some part of the income of the applicant's spouse is "available," the state must ignore that "available" income if the spouse refuses to pay. Indiana must advance the full amount of the applicant's covered medical expenses and then attempt to recoup the money from the reluctant spouse. 617 F.2d at 1232.

In *Herweg* v. *Ray*, *supra*, the Eighth Circuit (by an equally divided court) affirmed a district court decision holding that under Section 1902(a)(17) of the Social Security Act, 42 U.S.C. 1396a(a)(17), Iowa, an SSI state, is required to make individual factual inquiries to determine what part of the income of an applicant's spouse is "available," and that Iowa may consider the income of a spouse without regard to the length of time that the applicant has been separated from his spouse. Since the Secretary was not a party to that proceeding, the district court refused to pass on the validity of the HHS regulations applicable in SSI states, but noted that to the extent the regulations limited the time period during which SSI states may consider the income of an applicant's spouse, they are inconsistent with the Medicaid statute.

These conflicting decisions are all based, at least in part, upon interpretations of the same statutory provision, 42 U.S.C. 1396a(a)(17). That section is one of the fundamental provisions governing Medicaid eligibility. Consequently, the divergent interpretations of the courts of appeals have posed serious problems for the Secretary in supervising the administration of state Medicaid programs. Because the Court will have the opportunity this Term to resolve the conflict in the circuits concerning the validity of "deeming" under the Medicaid Act (see *Brown* v. *Stanton*, *supra*), it should consider the closely related issue raised in this case as well.

2. The court of appeals correctly held that the Medicaid statute does not preclude consideration of the income of an applicant's spouse (App. A, *infra*, 18a). Nevertheless, the court concluded that because of the "statute's strong emphasis upon flexibility" (*id.* at 23a), and the requirement that "the evaluation of income and resources be reasonable" (*ibid.*), and because "[t]he [state] eligibility requirements * * * must take into account only such income and resources as are available to the Medicaid applicant and must as well recognize the costs incurred by the individual for medical care, 42 U.S.C. § 1396a(a)(17)(B),(D)" (*id.* at 24a), Mississippi must adopt a flexible means test (*id.* at 25a-26a):

> We agree with the District Court that the amount necessary for the spouse to live in the community shall be calculated on the basis of a reasonable and realistic estimate of the amount necessary to cover the costs of food, clothing, and shelter, which may vary in particular localities. Further, this estimate must take into consideration the reasonable costs of necessary medical care, reasonable expenses of employment, and such other expenses as are reasonably determined by the state to be necessary for the fulfillment of the spouse's *basic living needs*.
>
> * * * The State may outline general guidelines for the use of local caseworkers. It must steer clear of rigid, blanket deductions to the exclusion of other factors.

The court of appeals erred in reading a flexible means test into the language of Section 1902(a)(17) of the Act, 42 U.S.C. 1396a(a)(17).

Pursuant to authority expressly delegated in Section 1902(a)(17), the Secretary has adopted regulations interpreting the term "available" income, as used in this provision, to include the income of an applicant's spouse at least to the extent that it would be considered in determining eligibility under Title XVI of the Social Security Act (SSI), 42 U.S.C. 1381 *et seq*. See 42 C.F.R. 435.723, 435.734. These regulations must be given legislative effect. *Batterton* v. *Francis*, 432 U.S. 416, 425–426 (1977). A reviewing court is not free to ignore such regulations solely because it would have adopted a different interpretation of the statutory phrase. See *id*. at 425. The standard of "available" income prescribed in the Secretary's regulations does not include a "flexible means" test, and the court of appeals expressly found that Section 1902(a)(17) "permits states to deem income from one spouse available to the other and that such deemed income is part of the 'available' income" states may consider in making Medicaid determinations (App. A, *infra*, 18a). The court below did not find that the Secretary's regulations were either arbitrary or capricious or contrary to law. Yet, the court impermissibly rejected the regulations' rea-

sonable definition of "available" income and substituted its own notion of what that term means.

In addition, the Secretary's regulations validly authorize states that have exercised the option under 42 U.S.C. 1396a(f) to "deem" income for purposes of Medicaid eligibility to the extent that they did so under their Medicaid plans on January 1, 1972. The 209(b) states are not *required* to use the 1972 standards; in accord with the purposes of 42 U.S.C. 1396a(f), the Secretary has left this decision to the individual states. As this Court observed in a similar context, when states are free to withdraw from participating in cooperative welfare programs, "a congressional intention to preclude the Secretary from recognizing legitimate local policies in determining eligibility" should not be lightly inferred. *Batterton* v. *Francis*, *supra*, 432 U.S. at 431-432. Here, the Secretary's regulations were adopted in light of a statutory provision, 42 U.S.C. 1396a(f), that was specifically intended to address the problem of state withdrawals. The Secretary's interpretation of the term "available" income to include the income of an applicant's spouse to the extent that the income would have been included under the 1972 plans—without the use of a "flexible means" test—is neither arbitrary nor capricious nor contrary to the provisions of Section 1902(a)(17). That interpretation of the term should have been followed by the court of appeals.

The statutory provisions and legislative history invoked by the court of appeals do not support its conclusion that "deeming" is permissible only if the state uses a "flexible" means test to determine the amount of income necessary to satisfy the needs of the applicant's spouse. The only flexibility "required" by the statute permits states to extend Medicaid coverage to persons who are ineligible for categorical assistance because of excess income, if they incur medical expenses that eliminate the "excess" income. The language of 42 U.S.C. 1396a(a)(17) is in pertinent part as follows:

> A State plan for medical assistance must—
>
> provide for flexibility in the application of such standards with respect to income by taking into account,

> except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of medical care recognized under State law * * *.

Unless the state adopts a program for the "medically needy," this provision is simply inapplicable. See *Fullington* v. *Shea*, 404 U.S. 963 (1971), aff'g 320 F. Supp. 500 (D. Colo. 1970); *Freeman* v. *Parham*, 475 F.2d 185 (5th Cir. 1973).

It is clear from the legislative history of the 1965 Medicaid amendments that Congress was not concerned with "flexibility" generally. The original Kerr-Mills program, which preceded Medicaid, did not require medical expenses to be considered, and the portions of the debates cited by the court of appeals deal specifically with this issue. Senator Long stated that "[t]he program for the needy elderly would be revised to require that the States must provide a flexible income test *which takes into account medical expenses* and does not provide rigid income standards which arbitrarily deny assistance to people *with large medical bills*." 111 Cong. Rec. 18349 (1965) (emphasis added). Senator Kuchel, whose remarks were relied on by the panel, stated that (111 Cong. Rec. 16145 (1965) (emphasis added)):

> Improvements would be effectuated in the program for the needy elderly by requiring that the States must provide a flexible income test *which takes into account medical expenses* and does not provide rigid income standards which deny assistance to people with *large medical bills*.

Similarly, Senator Ribicoff remarked (111 Cong. Rec. 15804 (1965) (emphasis added)):

> Finally, the bill would require States to apply means tests on a flexible basis, so as to take into account not only the individual's income, *but also the cost and extent of medical care he requires*.

The flexibility required by the statute thus was intended to correct only one problem, that of individuals whose income after deducting medical expenses would satisfy the eligibility standards for the categorical assistance pro-

grams, if the state chose to extend coverage to the "medically needy." Congress was not here speaking to the concept of deeming; this provision cannot reasonably be read to require individual consideration of the costs of food, clothing, shelter, medical care, and expenses of employment of the spouse of every Medicaid applicant. Furthermore, 42 U.S.C. 1396a(a)(17)(C), relied on by the court of appeals, speaks only to evaluation of assets of *the applicant* and not the availability of the income of his spouse. Hence, the authority relied upon by the court of appeals cannot support the broad flexibility requirement the court articulates.

Congress intended the Medicaid program to fit the financial realities of each state. Senator Ribicoff noted that (111 Cong. Rec. 15804 (1965)):

> [t]he bill would require that the means test for medical assistance be the same as that applied to cash benefits under other State public assistance programs * * *.

It has long been held that under the categorical assistance programs states are free to set both the standard of need and amount of benefits at the level they desire.[9] As this Court stated in *King* v. *Smith*, 392 U.S. 309, 318-319 (1968 (footnote omitted)):

> There is no question that States have considerable latitude in allocating their AFDC resources, since each State is free to set its own standard of need and to determine the level of benefits by the amount of funds to be devoted to the program.

Since the Medicaid statute only required participating states to provide medical assistance to recipients of benefits under one of the cash assistance programs, these decisions also determined, in large part, the Medicaid obligations of the participating states.

The structure of the Medicaid statute indicates Congress's intent to leave much to the discretion of the participating states. States are only required to provide the five services set out in 42 U.S.C. 1396d(a)(1)-(5). The

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[9] See generally *Jefferson* v. *Hackney*, 406 U.S. 535 (1972).

statute makes clear that the purpose of the program is to provide medical assistance "as far as practicable under the conditions in such State[s] * * *." 42 U.S.C. 1396. Thus, a state may choose whether or not to participate in the Medicaid program, may set eligibility levels, and may determine, within the limits of the statute, the scope of services offered. State legislatures have the obligation to allocate limited funds between Medicaid and other programs and to make funding decisions within the Medicaid program itself. Mississippi, like many other states, provides optional services such as prescription drugs and intermediate care facility services. To the extent that the decision of the court of appeals makes more people eligible for Medicaid or increases the amount of benefits for those receiving Medicaid, it may force states to cut back on such optional services. The statute, however, leaves to the *states* the difficult questions of allocation; the courts should not intervene in this area through imposition of "flexibility" standards not required by Congress.

We have been informed that, in response to the court of appeals' decision in this case and the decision in *Gray Panthers* v. *Secretary of HEW*, 461 F. Supp. 319 (D. D.C. 1978), aff'd and modified, No. 79-1334 (D.C. Cir. July 29, 1980), Mississippi has decided to become an SSI state effective July 1981. See Miss. Ann. Code § 43-13-115 (1972), as amended in Mississippi Senate Bill No. 2118 (May 21, 1980). This change in policy will cause hardship for individuals who presently qualify for Medicaid under the "spend-down" provisions of 42 U.S.C. 1396a(f), but who will no longer be able to qualify for Medicaid unless the state adopts a program for the "medically needy." One of the factors influencing Mississippi's decision was the difficulty in applying the "flexible deeming" requirements prescribed by the court of appeals.

3. Section 1902(f) of the Act, 42 U.S.C. 1396a(f), provides states with the option to restrict the Medicaid eligibility of aged, blind, and disabled individuals to those who would have been eligible for Medicaid "had [the state's] plan for medical assistance approved under this title [XIX] and in effect on January 1, 1972, been in effect in

[the] month" that the individual applies for Medicaid. If the flexibility contemplated by the court of appeals with regard to "reasonable amounts" that must be taken into account before "deeming" may occur reflects current standards (and not what the standards would have been in 1972), the decision is contrary to the intent of Congress in enacting 42 U.S.C. 1396a(f). Any guidelines that require a state to raise its standards for determining the "reasonable amount" necessary for living in the community for any date beyond January 1, 1972, would (due to inflation) require the states to adjust upward the levels contained in their 1972 plans. To do so would result in requiring the states to cover many aged, blind, or disabled individuals whom they would not have been required to cover on January 1, 1972. This result conflicts with the language of 42 U.S.C. 1396a(f).

## CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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SEPTEMBER 1980

# APPENDIX A

NONNIE MAE NORMAN ET AL., PLAINTIFFS-APPELLANTS,

*v.*

FRED ST. CLAIR ET AL., DEFENDANTS-APPELLEES.

NONNIE MAE NORMAN, ET AL., PLAINTIFFS-APPELLEES,

*v.*

FRED ST. CLAIR ET AL., AND PATRICIA ROBERTS HARRIS, SECRETARY OF HEALTH AND HUMAN RESOURCES, DEFENDANTS-APPELLANTS.

NELLIE WILLIAMS ET AL., PLAINTIFFS-CROSS APPELLEES.

MINNIE MERLI, AND ALL OTHERS SIMILARLY SITUATED IN HER CLASS, PLAINTIFF/APPELLANT, CROSS-APPELLEE,

*v.*

FRED ST. CLAIR ET AL., AND PATRICIA ROBERTS HARRIS, SECRETARY OF HEALTH AND HUMAN RESOURCES, DEFENDANTS-APPELLEES, CROSS-APPELLANTS.

**Nos. 77-1722, 79-2471.**

United States Court of Appeals, Fifth Circuit.

Jan. 28, 1980

Appeals from the United States District Court for the Southern District of Mississippi.

Before COLEMAN, *Chief Judge*, and RONEY and FAY *Circuit Judges*.

COLEMAN, *Chief Judge*.

This case and its companion, *Williams* v. *St. Clair*,[1] require an exploration of the complexities of Medicaid regu-

[1] *Norman* v. *St. Clair*, No. 77-1722, was brought in the Southern District of Mississippi, and *Williams* v. *St. Clair*, 610 F.2d 1244, No. 78-1625, was filed in the Northern District of Mississippi. They were subsequently consolidated in the Southern District and the District

lations, state and federal. Here, we examine Mississippi's "deeming" procedures. In *Williams* we consider "spend-down" regulations. We uphold the use of deeming as against both statutory and constitutional attack.

In these class actions the plaintiffs[2] challenge the Mississippi state practice of deeming the income of one spouse to be available for the support of the other spouse in (1) the calculation of Medicaid eligibility and in (2) the determination of the amount of the Medicaid payment.[3] The cases present a double attack on the deeming policy: (1) where the spouses are living together and (2) where one spouse is institutionalized and the other lives at home. Additionally, plaintiffs challenged the state practice of including one spouse's Old Age, Survivors and Disability Insurance (OASDI) benefits in calculating the other spouse's eligiblity for Medicaid. Finally, they challenged state treatment of deductions for dependent children in Medicaid calculations.

Plaintiffs sought a preliminary injunction. After an evidentiary hearing, the District Court denied the preliminary injunction and an appeal was taken to this Court. We granted an injunction pending appeal. Class certification was denied in No. 77-1722 and granted in 610 F.2d 1244, No. 78-1625.[4]

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Court issued one judgment covering both cases. The appeal from the consolidated decision is No. 79-2471. For convenience, in our opinion in *Norman* we treat all the deeming issues raised in both cases, and in *Williams* we dispose of the spend-down questions. This corresponds to the posture of the original briefing in both cases.

[2] Because plaintiffs and defendants both attack portions of the district court opinion, to avoid confusion we shall refer to the parties according to their stance in the lower court.

[3] Defendants are the Commissioner of the Mississippi State Department of Public Welfare, the Secretary of the Department of Health, Education, and Welfare, the Director of the Mississippi Medicaid Commission, the members of the State Board of the Mississippi State Department of Public Welfare, and the members of the Mississippi Medicaid Commission.

[4] The relevant classes were defined as follows: (1) all married persons in the State of Mississippi (a) who are separated from their

The issue was submitted on the merits in a stipulated record before a magistrate. The magistrate found the state's deeming process to be contrary to the medicaid statute. The District Court adopted the magistrate's order as the judgment of the district court. Upon a motion by defendants for alteration and amendment, the District Court allowed a form of deeming if the spouses live together. This appeal followed. The appeals from the denial of the preliminary injunction and from the decision on the merits were consolidated. We decide them together.

## 1. BACKGROUND

### A. The Operation of the Medicaid Program

In an effort to make medical services for the needy more generally available, Congress in 1965 established a federal program, denominated "Medicaid". This program was designed to liberalize the federal law under which states operate their medical assistance programs. H. Rep. No. 213, 89th Cong., 1st Sess. (1965); S. Rep. No. 404, 89th Cong., 1st Sess. (1965), reprinted in [1965] U.S. Code Cong. & Admin. News, pp. 1943, 2014.

Under Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, state medical assistance plans which meet certain general standards are eligible for federal assistance under what is essentially a matching funds formula. The state becomes entitled to grants of federal funds in

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spouses, (b) who are receiving no support from their spouses, whose spouses are over 65 years of age, blind, or permanently and totally physically or mentally disabled, and (c) who would be eligible for Medicaid assistance except for the income or resources of their spouses; (2) all married persons in the State of Mississippi (a) who live with their spouses, (b) who are receiving some support from their spouses, (c) who are over 65 years of age, blind, or permanently and totally physically or mentally disabled, and (d) who would be eligible for Medicaid assistance except for the income of their spouses; (3) all married persons in the State of Mississippi (a) whose spouses are over 65 years of age, blind or permanently and totally physically or mentally disabled and (b) who received Social Security benefits pursuant to the OASDI program.

reimbursement for a portion of the expenditures made in providing specific types of medical assistance to eligible individuals under the plan, where done in accordance with federal requirements. The Medicaid program is funded through the Department of Health, Education and Welfare but individual states receive wide discretion in the administration of their local programs. Although a number of federal legal and policy provisions affect state action under the program, the state has the responsibility for, *inter alia*, establishing the level of reimbursement for providers of services and determining the scope of services to be offered under the particular state's program. Participating states must, however, provide five general categories of medical services to individuals classified as "*categorically needy*": (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing facilities, screening and treatment for persons under the age of 21, and family planning services and supplies; and (5) physicians services.[5]

States are not required to participate in the Medicaid program but if they choose to do so they must submit to the Secretary of Health, Education and Welfare a state plan which meets all requirements of the Act. The state plan describes the nature and scope of the state program and provides assurances that the state will administer that program in conformity with the requirements of the federal guidelines. 42 U.S.C. § 1396a(b). *Beal* v. *Doe*, 432 U.S. 438, 441, 97 S.Ct. 2366, 53 L.Ed.2d 464 (1977); *Preterm, Inc.* v. *Dukakis*, 1 Cir. 1979, 591 F.2d 121, 124,

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[5]*See, e.g., Preterm, Inc.* v. *Dukakis*, 1 Cir. 1979, 591 F.2d 121, 124-25, *cert. denied sub nom. Preterm, Inc.* v. *King*, 441 U.S. 952, 99 S.Ct. 2182, 60 L.Ed.2d 1057 (1979); *Roe* v. *Norton*, 2 Cir. 1975, 522 F.2d 928, 932-33; *Johnson's Professional Nursing Home* v. *Weinberger*, 5 Cir. 1974, 490 F.2d 841, 842-43; *Arizona State Dep't of Public Welfare* v. *Department of Health, Education & Welfare*, 9 Cir. 1971, 449 F.2d 456, 460-61, *cert. denied*, 405 U.S. 919, 92 S.Ct. 945, 30 L.Ed.2d 789 (1972); *Connecticut State Department of Public Welfare* v. *Department of Health, Education & Welfare*, 2 Cir. 1971, 448 F.2d 209, 211; *Opelika Nursing Home, Inc.* v. *Richardson*, 5 Cir. 1971, 448 F.2d 658, 660-61.

*cert. denied sub nom. Preterm, Inc.* v. *King*, 441 U.S. 952, 99 S.Ct. 2182, 60 L.Ed.2d 1057 (1979); *White* v. *Beal*, 3 Cir. 1977, 555 F.2d 1146, 1149.

In 1969 Mississippi elected to participate in the Medicaid program and its state plan subsequently received HEW approval. The state plan is under the general supervision of the Mississippi Medicaid Commission and is administered by the Mississippi Department of Public Welfare. Miss.Code Ann. § 43-13-101 *et seq.*

Under the federal program as it was originally established in 1965, participating states were required to provide medical assistance to those individuals receiving aid from the four general categorical assistance welfare programs, Aid to the Aged (Title I), Aid to the Blind (Title X), Aid to the Disabled (Title XIV), and Aid to Families with Dependent Children (Title IV). 42 U.S.C. § 1396a (a)(10)(A); 42 C.F.R. 435.4. These programs were themselves joint federal-state efforts, administered by the states. Additionally, the Medicaid provisions allowed states to include individuals whose incomes exceeded the *categorical* assistance levels but whose resources were not sufficient to meet the costs of necessary medical and remedial care and services. These individuals are referred to as "*medically needy*". 42 U.S.C. § 1396a(a)(10)(A), (C); 42 C.F.R. § 435.301; *Preterm, Inc.* v. *Dukakis*, 1 Cir. 1979, 591 F.2d 121, 124, *cert. denied sub nom. Preterm, Inc.* v. *King*, 441 U.S. 952, 99 S.Ct. 2182, 60 L.Ed.2d 1057 (1979). *See also Friedman* v. *Berger*, 2 Cir. 1976, 547 F.2d 724, 726, *cert. denied*, 430 U.S. 984, 97 S.Ct. 1681, 52 L.Ed.2d 378 (1977). However, Mississippi chose not to have a *medically needy* program and that is not involved in this litigation.

In 1972 Congress revamped the categorical assistance programs, replacing federal-state aid to the aged, blind, and disabled with a fully federal scheme, known as the Supplemental Security Income Program (SSI), Title XVI, 42 U.S.C. § 1381 *et seq.* *See* Pub.L. No. 92-603 (1972). The states retained responsibility for administering the program of aid to families with dependent children. In

many states, Mississippi included, the federalizing of the categorical assistance welfare grant programs would make more people eligible for assistance than had been eligible under the state-administered scheme. Therefore, to avoid overwhelming the states with an immense increase in Medicaid rolls, Congress allowed the states the option of including only those individuals *who met the eligibility requirements for the state-administered programs on January 1, 1972*, rather than determining Medicaid eligibility according to the standards of the new SSI program. Pub.L. No. 92-603 § 209(b); 42 U.S.C. § 1396a(f); 42 C.F.R. § 435.1(d); *Hayes v. Stanton*, 7 Cir. 1975, 512 F.2d 133, 136-38. States which opted for the more restrictive 1972 standards are referred to as "209(b) states."[6] Mississippi is a "209(b)" state. Miss. Code Ann. § 43-13-115.

At the same time, Congress did not intend that those SSI recipients who did not meet their state's 1972 financial standards should be absolutely precluded from participation in the Medicaid program. It therefore required that states which employ the January 1, 1972, eligibility standards shall incorporate a "*spend-down*" provision. This allows those individuals who would be eligible under the SSI standards to deduct their incurred medical expenses from their income. This spend-down would enable needy individuals to become eligible for Medicaid when that part of their incomes in excess of the 1972 eligibility standards is consumed by expenses for medical needs. Pub. L. No. 92-603 § 209(b); 42 U.S.C. § 1396a(f); H. Rep. No. 92-231, 92d Cong., 1st Sess. (1971), reprinted in [1972] U.S. Code Cong. & Admin. News pp. 4989, 5061; *Hayes* v. *Stanton*, *supra*.

B. Mississippi's Program

At the time these cases arose, employing its January 1, 1972, standards, Mississippi calculated Medicaid decisions

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[6] Pub.L. No. 92-603 § 209(b) added § 1902(f) to the Social Security Act, 42 U.S.C. § 1396a(f).

on Form DPW-368 (revised 8-1-76).[7] The state's procedure used deeming, which is the assumption that a portion of one spouse's income is available for the support of the other, at two stages of the calculations: First, in determining Medicaid eligibility; Second, in determining "Medicaid income", which is the amount the recipient must himself pay for medical expenses. When each spouse is technically eligible in his own right and both request Medicaid, their incomes are considered mutually available and medical expenses are mutually attributable to either or both. A spouse who is technically eligible may not wish to apply. If so, the income of the spouse declining to apply is considered available to the applying spouse in the same manner as that of an ineligible spouse. *See* Mississippi Department of Welfare Manual, Vol. III, § M, p. 9645 (1-1-78) [hereinafter cited as Welfare Manual].

We now outline the procedure for computing the income for a technically eligible applicant with an ineligible spouse.

To determine eligibility, the state computes the "net *monthly* income" of the spouse by adding net wages [gross wages, less social security withholdings, taxes, and work expenses] to that spouse's other forms of income [e.g., social security benefits]. From this net income a uniform deduction ($78) is subtracted for the needs of the ineligible spouse. Additional deductions for minor dependent children are then subtracted. The allowances are $65 per child, less any income the child actually receives (e.g., social security or insurance benefits). The subtraction of these deductions from the net monthly income produces the amount of income which is deemed available to the

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[7] Because of the injunction pending appeal and the decision on the merits, Mississippi now uses procedures different from those in effect when these suits were filed. With the exception of certain minor changes in income levels and deduction amounts, however, the state seeks to continue the procedure in effect before the court orders in these cases. The state's regulations are found in Volume III of the Mississippi Department of Welfare Manual, Policies and Procedures for Administration of Public Assistance.

other spouse (the Medicaid applicant). The deemed amount is then added to the applicant's monthly cash income, from which a small disregard ($7.50) is subtracted. If the total is less than $150 where the applicant lives at home, or $450 where the applicant is institutionalized, the applicant qualifies for Medicaid.[8] If it is greater than these respective amounts, the applicant is not immediately eligible for Medicaid unless he is able to take advantage of the state spend-down procedure. *See* Welfare Manual, Vol. III, § M, pp. 9645–9649b, 9658–9660.

Once eligibility is established, the state then turns to determining how much of the medical expense an institutionalized recipient must bear himself. This is done by adding the recipient's net monthly income (income minus the $7.50 disregard) to the net monthly income of the spouse. From this total net income of recipient and spouse, a small allowance for the recipient's personal incidentals and clothing ($34.00) is subtracted. An additional allowance for the needs of the ineligible spouse ($140)[9] is then deducted, yielding net income after needs of the spouse are met. From this is subtracted allowances for minor dependent children ($65 minus income of the dependent child). This produces a figure, known as "Medicaid income," which the recipient must pay for medical services. Whenever the net income of the *ineligible* spouse exceeds the $140 allowance, the excess is, in effect, deemed available to the Medicaid recipient for purposes of paying medical expenses.

C. Facts

At the time of the suit, 79-year-old Troy Norman was institutionalized in a skilled nursing home in Mississippi. According to affidavit testimony, Mr. Norman's health was such that he could not receive the proper nursing care

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[8] The income level is now $175 where the applicant lives at home. The disregard amount has been increased to $10. *See* Form DPW-368 (revised 7-1-79).

[9] This amount is now $175. See Form DPW-368 (revised 7-1-79).

from his wife at home. He received a monthly Social Security disability check for $160.50. He had no other source of income and was eligible for Medicaid.

Troy Norman's wife, Nonnie Mae, lived in the community with their 14-year-old son Thomas. According to the findings of the magistrate, Mrs. Norman had a monthly employment income of $298.26 (excluding taxes, social security, and employment-related expenses) and received monthly social security checks for $47.90. Their son Thomas also received a social security check of $47.90. Mrs. Norman was not eligible for Medicaid. Application of the state's calculation of Medicaid eligibility and Medicaid income yields the following:

| | |
|---|---|
| Net monthly income of ineligible spouse | $346.16 |
| Less standard allowance for spouse's needs | 78.00 |
| | 268.16 |
| Less allowance for minor child ($65.00–$47.90) | 17.10 |
| Deemed Income | $251.06 |

The deemed income from Mrs. Norman is added to Mr. Norman's income (minus the $7.50 disregard) producing a total income available to Mr. Norman of $404.06. Since this is less than $450, Mr. Norman is eligible for Medicaid.

To determine how much of his medical expenses Mr. Norman must pay himself, the state calculates as follows:

| | |
|---|---|
| Net monthly income of Mr. Norman | $153.00 |
| Net monthly income of Mrs. Norman | 346.16 |
| Total net monthly income of both | 499.16 |
| Less allowance for Mr. Norman | - 34.00 |
| | 465.16 |
| Less allowance for Mrs. Norman | 140.00 |
| | 325.16 |
| Less allowance for unmet needs of Thomas ($65.00–47.90) | - 17.10 |
| Equals "Medicaid Income" to be paid by Normans to nursing home | $308.06 |

The state's allowance of $140.00 for Mrs. Norman's living expenses is a uniform amount which does not vary.

As these figures suggest, $189.06 of Mrs. Norman's income *is deemed* available to Mr. Norman to be used in paying his nursing home medical expenses. *Plaintiffs contend that $189.06 is not in fact available to Mr. Norman and to deem it so violates the Medicaid statute, 42 U.S.C. § 1396a(a)(17).*

In testimony before the magistrate Mrs. Norman stated her monthly expenses as follows:[10] mobile home payment, $79.85; electricity, $80; butane gas, $65; car payments, $56.18; tire payments, $27; car insurance, $32; food, $129; clothing, $10; gasoline, $25; Thomas' tuition at a local private academy, $67; Thomas' bus ride to school, $20. Mrs. Norman testified that she also had to pay approximately $16 a month for her husband's medicine, which Medicaid did not pay for. She stated that she was able to pay her recent expenses only because she received an income tax refund of $491 and that she had gotten behind on several of her accounts. Since these expenses exceed her income, she contends, no income should be deemed available to her husband. Plaintiffs further assert that deeming the income available when it in fact is not would result in Mr. Norman's being unable to pay his nursing home bill, forcing him to leave the nursing home. Plaintiffs argue also that by subtracting Thomas' social security check from the $65 dependent child allowance the state is deeming Thomas' income available to his father, thereby forcing Thomas to support his father in violation of 42 U.S.C. § 1396a (a)(17)(D).

Nellie and Robert Williams are a couple who both live at home. Mrs. Williams, who is over 65, is potentially eligible for Medicaid. Her husband is not. According to findings of the magistrate, Mrs. Williams receives $40 in Supplemental Security Income (SSI) benefits per month. Her husband receives $266 per month in OASDI benefits and retirement funds. The calculations thus run as follows:

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[10] Although Mrs. Norman's testimony on expenses was uncontradicted, the magistrate, in his denial of a preliminary injunction, said he felt the expenses "seem out of line".

| | |
|---|---|
| Total monthly income of Mr. Williams | $266.00 |
| Less standard deduction for living expenses of ineligible spouse | - 78.00 |
| Equals amount "deemed" available to Mrs. Williams | $188.00 |
| Plus monthly income of Mrs. Williams ($40–$7.50 disregard) | 32.50 |
| Equals total income of Mrs. Williams | $220.50 |

Because $188 of Mr. Williams' income is deemed available to Mrs. Williams, she is ineligible for Medicaid. In arriving at this figure, the state uses a uniform allowance of $78.00 for the living expenses of the spouse. The amount of this deduction never varies.

Wharey S. Wilson and his wife Jane are both potentially eligible for Medicaid. Mr. Wilson resides in a nursing home, while Mrs. Wilson lives at home. Under the state's policy, the joint incomes of the Wilsons are pooled for purposes of determining Mr. Wilson's Medicaid eligibility as a nursing home patient. As a result of Social Security and Veterans Administration cost-of-living increases, the Wilson's joint income exceeded the eligibility cut-off by $48.65, making them both ineligible because of the deeming of each spouse's income to the other.[11] They challenge this policy.

Finally, plaintiffs attacked Mississippi's practice of considering one spouse's OASDI benefits available to the other. Jane Wilson's $164.30 in OASDI benefits is pooled with the income of her husband in determining their Medicaid eligibility. Likewise Wharey Wilson's $107.90 is pooled with the income of Mrs. Wilson. Part of Mr. Williams' $206.40 in OASDI income is deemed available to Nellie Williams for Medicaid purposes. Plaintiffs contend this deeming of OASDI benefits constitutes an illegal garnishment under 42 U.S.C. § 407.

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[11] At the time of the district court decision, the Wilsons were apparently eligible. The issue then was deeming for the purpose of determining the amount of Medicaid payments.

## II. DEEMING

Plaintiffs contend that Mississippi's deeming procedures and HEW's guidelines permitting such procedures violate the text, legislative history, and general intent of the Medicaid statute. They argue that the statute requires states to consider only such income as the spouse, in effect, *physically gives the applicant.*

We begin with a preliminary inquiry into implications of the § 209(b) exception. We then proceed to a close analysis of the Medicaid eligibility statute. Since we find that the statute permits Mississippi's practice, we also reach the constitutional issue.

### A. The § 209(b) Exception

Mississippi employs the more restrictive eligibility guidelines permitted by § 209(b) of Pub. L. No. 92–603, 42 U.S.C. 1396a(f), the relevant portion of which reads as follows:

> Notwithstanding any other provision of this subchapter, . . . no State not eligible to participate in the State plan program established under subchapter XVI of this chapter [the SSI program] shall be required to provide medical assistance to any aged, blind, or disabled individual . . . unless such State would be (or would have been) required to provide medical assistance to such individual . . . had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect [at the time of assistance], except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1396b(f) of this title (after deducting any supplemental security income payment made with respect to such individual, and incurred expenses for medical care as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972.

Mississippi contends that this exception precludes the court from interpreting other sections of the Medicaid act to require the state to extend coverage broader than that existing in 1972.

Although § 209(b) allows states to use standards more restrictive than those under the SSI program, the provision can not be viewed as an all-purpose "grandfathering" clause which effectively legitimizes any and every provision appearing in a state plan in 1972. We find no indication that in passing § 209(b) Congress intended to authorize otherwise improper procedures. In other words, if, in January, 1972, the state's deeming procedure was impermissible under 42 U.S.C. § 1396a(a)(17), it cannot now be made acceptable simply because of § 209(b).

This necessitates an examination of whether the state's practice violates the Medicaid eligibility statute, 42 U.S.C. § 1396a(a)(17), and its implementing regulations.

B. Statutory Analysis

The statutory requirements for state eligibility standards are found at 42 U.S.C. § 1396a(a)(17) and in the implementing regulations, 42 C.F.R. part 435.[12] Because of its critical importance we set out the statute in full.

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[12] At the time these suits were filed, HEW regulations, 45 C.F.R. 248.3 required that a state plan must "provide that only such income and resources as are actually available will be considered." This was revised and recodified in April 1977 at 42 C.F.R. 448.3(b)(1) to read that a state plan must "[p]rovide that only such income and resources as are considered available under this section may be considered as an applicant's or recipient's income in determining eligibility or the amount of assistance and that income and resources will be reasonably evaluated." This change in effect imposed different requirements in different jurisdictions because of the states' option to use pre-SSI eligibility standards. *See Gray Panthers v. Secretary, Dep't of HEW*, 461 F.Supp. 319 (D.D.C. 1978). A subsequent recodification of the Medicaid regulations has deleted this subsection entirely. The financial eligibility guidelines for states using more restrictive requirements than SSI are now found at 42 C.F.R. §§ 435.731-435.740. For our purposes the relevant section is 42 C.F.R. § 435.734, which reads as follows:

A State plan for medical assistance must . . . include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives

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In determining medicaid eligibility of an aged, blind, or disabled individual under requirements more restrictive than those used under SSI, the agency must consider the income and resources of spouses and parents as available to the individual in the manner specified in §§ 435.723 and 435.724 or in a more extensive manner, but not more extensive than the requirements in effect under the medicaid plan on January 1, 1972.

§ 435.723 states:

(a) If the agency provides medicaid to SSI recipients, it must meet the requirements of this section in determining eligibility of aged, blind, and disabled individuals under the optional coverage provisions of §§ 435.210, 435.211, and 435.231.

(b) The agency must consider income and resources of spouses living in the same household as available to each other, whether or not they are actually contributed.

(c) If both spouses apply or are eligible as aged, blind, or disabled and cease to live together, the agency must consider their income and resources as available to each other for the first 6 months after the month they cease to live together. After this 6-month period, the agency must consider only the income and resources that are actually contributed by one spouse to the other.

(d) If only one spouse in a couple applies or is eligible and they cease to live together, the agency must consider only the income and resources of the eligible spouse that are actually contributed to the eligible spouse after the month in which they cease to live together.

§ 435.724 deals with the financial responsibility of parents for blind or disabled children and is not relevant to the discussion here.

> of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law. . . .

The 89th Congress established the Medicaid program as ancillary to a broader, more comprehensive health care scheme, commonly known as Medicare.

From the very language of the statute, Congress clearly intended that insofar as Medicaid eligibility is concerned one spouse must assume responsibility for the other in providing medical care. The specific language of the act allowed states to "take into account the financial responsibility" of the Medicaid applicant's or recipient's spouse. 42 U.S.C. § 1396a(a)(17)(D). Moreover, Congress made it clear that states could not extend this responsibility be-

yond the spouse to children or other relatives. Both the House Ways and Means Committee of the Senate Finance Committee in their reports on H.R. 6675 expressed their views in similar language:

> The committee has heard of hardships on certain individuals by requiring them to provide support and to pay for the medical care needed by relatives. The committee believes it is proper to expect spouses to support each other and parents to be held accountable for support may reasonably include the payment by or permanently and totally disabled children even though 21 years of age or older. Such requirements for support may reasonably include the payment of such relative, if able, for medical care. Beyond such degree of relationship, however, requirements imposed are often destructive and harmful to the relationships among members of the family group. Thus, States may not include in their plans provisions for requiring contributions from relatives other than a spouse or the parent of a minor child or children over 21 who are blind or permanently and totally disabled. Any contributions actually made by relatives or friends, or from other sources, will be taken into account by the State in determining whether the individual applying for medical assistance is, in fact, in need of such assistance.

S. Rep. No. 404, 89th Cong., 1st Sess. (1965), reprinted in [1965] U.S. Code Cong. & Admin. News, pp. 1943, 2018, H. Rep. No. 213, 89th Cong., 1st Sess. 68 (1965).

In providing for limited accountability Congress was responding to a spate of state laws under Kerr-Mills which had denied coverage to individuals whose relatives had sufficient income to support the Medicaid applicant or whose state relative responsibility laws required such support. In particular Congress was acting to remove those state tests which had looked to the ability of children to support their elderly parents. *See, e.g.*, 111 Cong. Record 15813, 16149 (1965).

Under the plain language of the statute, the states were left to establish and prosecute the responsibility of spouses as a matter of their own discretion. While they might

prefer to do this through available statutory and judicial techniques of forcing one spouse to assume the financial needs of the other, in the context of the Medicaid program they are just as free to do so by regulation.

Plaintiffs contend that permitting states to use deeming as a method of taking into account the financial responsibility of the spouse violates the requirement of 42 U.S.C. § 1396a(a)(17)(B) that states include only that income which, in the words of the Senate report, is "actually available." Yet, it is just this juxtaposition with the deeming of one spouse's income which the drafters of the legislation themselves recognized and approved. Thus Senator Long, who headed the Senate's Conference delegation, summarized the conference provisions as follows: "No income can be imputed to an individual unless actually available; and the financial responsibility of an individual for an applicant may be taken into account only if the applicant is the individual's spouse. . . ." 111 Cong. Rec. 18349 (July 27, 1965). This indicates that Congress intended that income deemed from a spouse to be a part of the "available" income which the state may consider in determining eligibility.

Such an interpretation is necessary as well to provide meaning to subsection (17)(D). If Congress had not considered the deeming of income permissible, there would have been no need for that subsection. Any payments the Medicaid applicant received by virtue of the state's enforcing a relative responsibility law would have been automatically included in income, while the failure of the state to enforce the relative responsibility law would have meant that the applicant would have received no income. Subsection (17)(D) thus envisions a different situation, one where the state has decided to hold one spouse financially responsible for the other but has not done so by judicial enforcement of a financial responsibility law (which would have produced income under subsection (17)(B), thereby rendering (17)(D) superfluous).

We must reject plaintiffs' contention that 42 U.S.C. § 1396a(a)(17)(D) merely authorizes the states to invoke

formal financial responsibility proceedings for the support of spouses. We hold instead that 42 U.S.C. § 1396a (a)(17(D) permits states to deem income from one spouse available to the other and that such deemed income is part of the "available" income which states may compute under 42 U.S.C. § 1396a(a)(17)(B).

In addition to the legislative history of this particular section, our decision finds support in other facets of the Social Security Act and in a common-sense approach to federal health assistance. First, we note that the federal Supplemental Security Income (SSI) program explicitly recognizes the propriety of deeming in determining eligibility for SSI benefits. *See* 42 U.S.C. § 1382(a)(2); 42 U.S.C. § 1382c(f)(1).[13] This is particularly important in light of the 1974 amendment to the Medicaid act which permitted states either to adopt SSI standards for Medicaid eligibility or, in the § 209(b) exception, to use the stricter standards which were in effect in 1972. Thus under certain circumstances Medicaid eligibility determinations in an "SSI state" must, because of the statutory mandate in the SSI legislation, take into account income that is deemed available, without regard to whether that income is actually contributed. Since this statutory mandate exists concurrently in the Medicaid law with the provision of 42 U.S.C. § 1396a(a)(17) directing that only income which is "available" be taken into account, it must be concluded that the income deemed to Medicaid applicants pursuant to provisions of law applicable to SSI states is available income. A concept of available income which includes income deemed to spouses in SSI states must also

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[13] 42 U.S.C. § 1382c(f)(1) provides:

> (f)(1) For purposes of determining eligibility for and the amount of benefits for any individual who is married and whose spouse is living with him in the same household but is not an eligible spouse, *such individual's income and resources shall be deemed to include any income and resources of such spouse, whether or not available to such individual*, except to the extent determined by the Secretary to be inequitable under the circumstances (emphasis added).

encompass income deemed to spouses in the more restrictive programs of the § 209(b) states.

Second, the use of deeming also comports with a reasonable approach to welfare programs. Without some form of deeming, spouses could shift all the income to one spouse, who might then either refuse to aid the other or incur exorbitant and unnecessary expenses, thus preventing aid to the eligible spouse. Indeed, the unemployed spouses of wealthy individuals could become prime candidates for Medicaid assistance. Such a result is bound to have been far from the intent of the Medicaid drafters. Yet it would be the ultimate consequence of the approach plaintiffs urge upon us. Although we are considering a program enmeshed in a maze of overlapping statutes and regulations, we cannot assume that Congress intended to abandon all reason or restraint.

The Supreme Court's decisions invalidating deeming under the Aid to Families with Dependent Children (AFDC) program do not control the cases before us. The narrow holdings of the Court in those cases cannot support the broader prohibition against deeming in assistance programs which plaintiffs urge upon us. In *King* v. *Smith*, 392 U.S. 309, 88 S.Ct. 2128, 20 L.Ed.2d 1118 (1968), the Court considered the validity of Alabama's "substitute father" regulation which denied AFDC payments to the children of a mother who cohabited in or outside her home with an able-bodied man. Under the Alabama plan, it was irrelevant whether the man had any legal obligation to support the children and whether he had in fact contributed to their support; the state, in effect, deemed the man's resources available for the support of the children. The Supreme Court rejected the Alabama deeming approach, but it did so not on the basis of deeming but on the limited grounds of statutory definition. The Court held the Alabama regulation invalid because it defined "parent" in a manner inconsistent with the AFDC sections of the Social Security Act. Only individuals with a legal obligation to support the child came within the statutory definition.

A similar approach guided the Court in *Lewis* v. *Martin*, 397 U.S. 552, 90 S. Ct. 1282, 25 L. Ed. 2d 561 (1970),

when it rejected a California AFDC law requiring consideration of the income of a stepfather or of an adult male assuming the role of a spouse to the mother although not legally married to her. The California law conclusively presumed that the needs of the children were reduced by the income of the man in the house, whether that income was in fact used to meet the children's needs. Again focusing upon the definition of parent, the court held that the Social Security Act precludes treating a person who is not a natural or adoptive parent as a "'breadwinner' unless the bread is actually set on the table." *Lewis* v. *Martin*, 397 U.S. at 559, 90 S. Ct. at 1286.

In the final opinion of its trilogy involving AFDC deeming plans, *Van Lare* v. *Hurley*, 421 U.S. 338, 95 S. Ct. 1741, 44 L.Ed.2d 208 (1975), the Court considered a New York regulation reducing pro rata the shelter allowance provided AFDC recipients to the extent there are nonpaying lodgers living in the household. The state procedure made the presence of the lodger a basis for assuming the availability of income. In rejecting New York's regulation, the court stated that *King* and *Lewis* "construe[d] the federal law and regulations as barring the States from assuming that nonlegally responsible persons will apply their resources to aid the welfare child." 421 U.S. at 347, 95 S. Ct. at 1747. The court thus continued to reject deeming of income from people whom Congress had not included in the definition of "parent".

In all three cases, upon which plaintiffs place considerable emphasis, the Court never addressed the propriety of deeming itself. In each case, the Court rejected an aspect of deeming because the state had improperly defined parent under the AFDC statute, an issue wholly absent here. Thus, contrary to plaintiffs' contention, the Supreme Court has not rejected the principle of deeming in the area of social services. Indeed in *Lewis* v. *Martin*, *supra*, the Court implicitly assumed that certain deeming techniques are acceptable.[14]

[14]The Court appears to sanction deeming in the following passage:

> We only add that HEW might reasonably conclude that only he

Our own decisions involving deeming have likewise been limited and do not reach to the cases now before us. In *Reyna* v. *Vowell*, 5 Cir. 1972, 470 F.2d 494, a review of a lower court dismissal order, we examined a Texas AFDC practice which presumed the availability to the entire family of income earned by a child between the age of 18 and 21 who lives in the family's household. Noting the Supreme Court's decisions in *King* and *Lewis* and the general policy against premature dismissal, especially where serious questions of public law may be presented, we remanded for an evidentiary hearing to enable plaintiff to establish facts to support his complaint. We did not engage in a full-scale inquiry into the propriety of deeming.

*Houston Welfare Rights Organization, Inc.* v. *Vowell*, 5 Cir. 1977, 555 F.2d 1219, *reversed on jurisdictional grounds sub nom. Chapman* v. *Houston Welfare Rights Organization*, 441 U.S. 600, 99 S. Ct. 1905, 60 L.Ed.2d 508 (1979), also involved a challenge to state regulations under the AFDC program. There we considered a Texas policy of budgeting only a pro rata share of shelter and utility expenses when a non-AFDC recipient shares a recipient's residence. Plaintiffs charged that the proration policy violated the federal guidelines by presuming that the ineligible individual living with the recipient contributes toward the shelter and utility expenses, thus reducing the need of the recipient. Unable to find a meaningful distinction between the statutory scheme struck down in *Van Lare*, *supra*, and the Texas policy, we concluded that *Van Lare* controls and found the proration procedure improper.

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who is as near as a real or adoptive father would be has that consensual relation to the family which makes it reliably certain that his income is actually available for support of the children in the household. HEW may, in other words, reasonably conclude that an obligation to support under state law must be of "general applicability" to make that obligation in reality a solid assumption on which estimates of funds actually available to children on a regular basis may be calculated.

397 U.S. at 558–59, 90 S.Ct. at 1285.

Thus in both *Reyna* and *Houston Welfare Rights Organization*, we based no holding on the validity of deeming per se. Our decisions rested upon specific statutory construction of AFDC and, of course, did not extend to an analysis of Medicaid programs.[15]

In upholding deeming, we are aware that the district courts which have confronted this issue have all rejected some form of Medicaid deeming.[16] Nevertheless, no appeals court has yet addressed the issue. For the reasons outlined above, we find the reasoning in these district

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[15] *Lopez v. Vowell*, 5 Cir. 1973, 471 F.2d 690, *cert. denied*, 411 U.S. 939, 93 S.Ct. 1903, 36 L.Ed.2d 401 (1973), and *Rodriguez v. Vowell*, 5 Cir. 1973, 472 F.2d 622, *cert. denied*, 412 U.S. 944, 93 S.Ct. 2777, 37 L.Ed.2d 404 (1973), were also challenges to eligibility practices under the AFDC program. *Lopez* involved the right of indigent non-parent caretaker relatives to receive AFDC benefits. A Texas law denied aid to caretakers of needy dependent children if the caretakers were married and were living with their spouses. Examining the statutory basis for AFDC aid, we held the regulation invalid because inconsistent with the Social Security Act. We found within the federal act a purpose to aid both the dependent children and the caretaker relative, without any indication that the caretaker must be single in order for his needs to be included in calculating AFDC aid.

*Rodriguez* likewise concerned aid to caretaker relatives of dependent children. Because of the congressional purpose to assist dependent children by also meeting the needs of their caretaker relatives, we rejected a Texas regulation which denied AFDC grants to families in which the child has income "in his own right" that is greater than his own state-defined recognizable needs, even though such income is less than the recognizable needs of both the child and his caretaker relative.

Although both cases involved welfare program eligibility, neither addressed deeming specifically and both were limited to strict statutory construction of the federal AFDC program.

[16] *See, e.g., Nursing Home Residents' Advisory Council v. Kelly*, 470 F.Supp. 747 (D.Minn. 1979); *Hanke v. Nyhus*, 470 F.Supp. 742 (D.Minn.1979); *Gray Panthers v. Secretary, Department of Health, Education and Welfare*, 461 F.Supp. 319 (D.D.C.1978); *Herweg v. Ray*, 443 F.Supp. 1315 (S.D.Iowa 1978); *Manfredi v. Maher*, 435 F.Supp. 1106 (D.Conn.1977); *Burns v. Vowell*, 424 F.Supp. 1135 (S.D.Tex.1976); *Franssen v. Juras*, 406 F.Supp. 1375 (D.Ore.1975).

court opinions unpersuasive. We decline to adopt their rationale.

We thus hold that deeming the income of one spouse available for the support of the other, both where the spouses live together and where one spouse is institutionalized,[17] is permissible under the Medicaid statute.

C. Flexibility

In holding as we have, we do not lose sight of the statute's strong emphasis upon flexibility in determining eligibility. We recall the legislative history which emphasizes an effort to avoid *arbitrary* and *rigid* income standards in calculating eligibility. *See, e.g.*, 111 Cong. Rec. 18349 (July 27, 1965) (statement of Sen. Long presenting summary of Conference Report on H.R. 6675). We note also the statute's requirement that the evaluation of income and resources be reasonable. 42 U.S.C. § 1396a(a)(17)(C).

The enactment of Medicaid was an effort to replace the then-existing Kerr-Mills medical assistance program for the aged with an expanded and more effective form of federally assisted state aid to needy individuals who required medical care. Under the optional and limited Kerr-Mills plan, state aid programs had covered only the aged, and many states had imposed rigid and complex eligibility standards. *See, e.g.*, S. Rep. No. 404, 89th Cong., 1st Sess. (1965), reprinted in [1965] U.S. Code Cong. &

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[17] Although HEW regulations prohibit deeming under SSI programs where eligible spouses have not lived together for six months, 42 C.F.R. § 435.723(c), or, in the case where only one spouse is eligible, as soon as they cease to live together, 42 C.F.R. § 435.723(d), 42 C.F.R. § 435.734 allows non-SSI states to use more extensive income tests, which presumably would include deeming in instances where the spouses cease to live together, i.e., where one spouse is institutionalized. In evaluating the needs of the couple to determine the applicant's income, however, the state must make reasonable adjustments which correspond to the changed nature of each spouse's expenses once they cease to live together.

Admin. News pp. 1943, 2014, 2018; 111 Cong. Rec. 15804 (July 7, 1965) (statement of Sen. Ribicoff).

House and Senate advocates of health care for the nation's needy pushed a bill which would expand the Kerr-Mills coverage and make the eligibility requirements more flexible while at the same time leaving to states substantial discretion in operating their programs and establishing eligibility tests. The result, new Title XIX of the Social Security Act, extended medical assistance coverage to those individuals receiving aid under the dependent children, blind, and permanently and totally disabled programs. The eligibility requirements, the act stated, must take into account only such income and resources as are available to the Medicaid applicant and must as well recognize the costs incurred by the individual for medical care. 42 U.S.C. § 1396a(a)(17)(B), (D).

Congress' desire to replace arbitrary means tests in calculating eligibility with more flexible ones appears clearly in the committee and conference discussions of the legislation. Senator Russell Long, presenting a summary of the conference-approved bill, noted that the "program for the needy elderly would be revised to require that the States must provide a flexible income test which takes into account medical expenses and does not provide rigid income standards which arbitrarily deny assistance to people with large medical bills." 111 Cong. Rec. 18349 (July 27, 1965). *See also* the remarks of Sen. Kuchel, presenting a summary of Senate Finance Committee Report on H.R. 6675, that states must provide "flexible income test which . . . does not provide rigid income standards", 111 Cong. Rec. 16145, July 9, 1965. Likewise, in reporting out its version of the bill, the House Ways and Means Committee expressed its commitment to flexible eligibility standards:

> Another provision is included that requires States to take into account *only such income and resources as* (determined in accordance with standards prescribed by the Secretary [of HEW]) *are actually available* to the applicant or recipient and as would not be disregarded (or set aside for future needs) in determining the eligibility for and the amount of the

> aid or assistance in the form of money payments for any such applicant or recipient under the title of the Social Security Act most appropriately applicable to him. *Income and resources* taken into account, furthermore, *must be reasonably evaluated by the States.* These provisions are designed *so that the States will not assume the availability of income which may not, in fact, be available* or overevaluate income and resources which are available. Examples of income assumed include support orders from absent fathers, which have not been paid or contributions from relatives which are not in reality received by the needy individual.

H.Rep. No. 213, 89th Cong., 1st Sess. 67 (1965) (emphasis added); *see also* S.Rep. No. 404, 89th Cong., 1st Sess. (1965), reprinted in [1965] U.S. Code Cong. & Admin. News pp. 1943, 2018, using the same language.

Individual supporters of the Medicaid legislation shared this view of flexible eligibility requirements. In floor remarks, Senator Abraham Ribicoff, for example, stated that the bill would "require that only income and resources actually available to an applicant may be considered in determining need." Furthermore, according to Ribicoff, the bill would require states "to apply a means test on a flexible basis. . . . It is reasonable to allow states to make determinations of need and eligibility for public assistance programs, but it is unreasonable to allow the standards of eligibility to be applied in such a way that they prevent assistance from reaching those who may need it most." 111 Cong. Rec. 15804 (July 7, 1965). Senator Saltonstall said that the bill "provides a more flexible means test". *Ibid.* at 16149; Senator McNamara, a cosponsor, said that the bill makes a "substantive and meaningful liberalization" in the Kerr-Mills program. *Ibid.* at 15876.

The state may consider as available to the Medicaid applicant or recipient all income of the spouse in excess of those expenses *necessary for the spouse to live in the community.* We agree with the District Court that the amount necessary for the spouse to live in the community shall be calculated on the basis of a reasonable and realistic estimate of the amount necessary to cover the costs of

food, clothing, and shelter, which may vary in particular localities. Further, this estimate must take into consideration the reasonable costs of necessary medical care, reasonable expenses of employment, and such other expenses as are reasonably determined by the state to be necessary for the fulfillment of the spouse's *basic living needs.*

The bottom line is that in the formulation of its applicable standards the state is not free to act arbitrarily or inflexibly but must stay within the reality of basic, fundamental facts as they apply to the status of the parties under consideration. The state may outline general guidelines for the use of local caseworkers. It must steer clear of rigid, blanket deductions to the exclusion of other factors.

D. Other Deeming Issues

We now turn briefly to plaintiffs' challenge in *Norman* to the state's practice of subtracting the Norman son's Social Security check from the $65 dependent child deduction. We find nothing wrong with the procedure. Contrary to plaintiffs' assertion, the state is not deeming Thomas' income to support his father which would be a clear violation of 42 U.S.C. § 1396a(a)(17)(D).

In calculating Mrs. Norman's income, the state allows her a deduction for the support of her son. But to the extent that her son has income enabling him to support himself, that deduction is reduced. While in this particular case the computation yields the same net result as if the son's income were added to the income of Mr. and Mrs. Norman and then a $65 deduction were taken, the same would not be true if the son's income exceeded the $65 deduction. In short, the Social Security check eats up a deduction; it is not deemed income. The state's practice does not violate the statute.

E. Constitutional Issues

Plaintiffs argue that deeming creates an irrebuttable presumption which denies due process and violates plain-

tiffs' rights of equal protection. They contend also that it illegally infringes upon the fundamental right to marriage.

The Supreme Court has upheld irrebuttable presumptions in a number of situations involving social services eligibility and has distinguished those cases in which the Court has struck down irrebuttable presumptions. *See, e.g., Califano* v. *Jobst*, 434 U.S. 47, 98 S.Ct. 95, 54 L.Ed.2d 228 (1977) (irrebuttable presumption of lack of dependency under Social Security Act when disabled dependent child of covered wage earner married an individual who is not entitled to benefits under the Act); *Usery* v. *Turner Elkhorn Mining Co.*, 428 U.S. 1, 96 S.Ct. 2882, 49 L.Ed.2d 752 (1976) (irrebuttable presumption under Black Lung Benefits Act of total disability due to pneumoconiosis based on clinical evidence of complicated pneumoconiosis); *Mathews* v. *Lucas*, 427 U.S. 495, 96 S.Ct. 2755, 49 L.Ed.2d 651 (1976) (presumption of dependency under Social Security Act of legitimate child of insured parent upon parent's death); *Weinberger* v. *Salfi*, 422 U.S. 749, 95 S.Ct. 2457, 45 L.E.d.2d 522 (1975) (irrebuttable presumption of duration-of-relationship Social Security eligibility requirement). *See also Richardson* v. *Belcher*, 404 U.S. 78, 92 S.Ct. 254, 30 L.Ed.2d 231 (1971); *Dandridge* v. *Williams*, 397 U.S. 471, 90 S.Ct. 1153, 25 L.Ed.2d 491 (1970)

At issue in *Salfi* was a Social Security regulation denying widow's benefits to one widowed within nine months of the marriage. The district court had held the regulation invalid as an irrebuttable presumption that marriages which did not precede the wage earner's death by at least nine months were entered into for the purpose of securing Social Security benefits. The Supreme Court reversed, holding that a non-contractual claim to receive funds from the public treasury enjoys no constitutionally protected status, though of course Congress may not invidiously discriminate among such claimants on the basis of a bare Congressional desire to harm a politically unpopular group or on the basis of criteria which bear no rational relation to a legitimate legislative goal. *U.S. Department of Ag-*

*riculture* v. *Moreno*, 413 U.S. 528, 93 S.Ct. 2821, 37 L. Ed. 2d 782 (1973).

The Court in *Salfi* then articulated the central constitutional question as follows:

> whether Congress, its concern having been reasonably aroused by the possibility of an abuse which it legitimately desired to avoid, could rationally have concluded both that a particular limitation or qualification would protect against its occurrence, and that the expense and other difficulties of individual determinations justified the inherent imprecision of a prophylactic rule.

422 U.S. at 777, 95 S.Ct. at 2472-2473.

We find that the deeming process is an acceptable and rational response to legislative concern over abuse of the Medicaid program by spouses who are not financially needy, that it does not invidiously discriminate among claimants, and that it is a proper general rule for the administration of a large fund with a "modicum of efficiency." *See Califano* v. *Jobst*, 434 U.S. at 53, 98 S.Ct. 95.

We also hold that Mississippi's deeming procedures do not unconstitutionally infringe upon the right of marriage. Mississippi's policy of considering the income of one spouse as available to meet the needs of the other spouse only incidentally burdens the marriage relationship. The Supreme Court has repeatedly recognized the "basic difference between direct state interference with a protected activity and state encouragement of an alternative activity consonant with legislative policy." *Maher* v. *Roe*, 432 U.S. 464, 475, 97 S.Ct. 2376, 2383, 53 L.Ed.2d 484 (1977). *See also Buckley* v. *Valeo*, 424 U.S. 1, 96 S.Ct. 612, 46 L.Ed.2d 659 (1976).

The consideration of part of one spouse's income as available to the other is based upon the congressional belief that "it is proper to expect spouses to support each other." S.Rep.No. 404, 89th Cong., 1st Sess. (1965), reprinted in [1965] U.S. Code Cong. & Admin. News pp. 1943, 2018. The consideration of the financial responsibility of one spouse for the other is not a substantial obstacle

or burden on the right of marriage. It is consistent with the belief that out of the marriage relationship arises a duty for the spouses to provide for each other's medical expenses.

F. Garnishment of OASDI Benefits

Plaintiffs argue that in determining eligibility for and the amount of benefits of Medicaid, Mississippi considers payments made to one spouse under Title II of the Social Security Act (OASDI), 42 U.S.C. § 401 *et seq.*, available to the other spouse and that this is a garnishment prohibited by 42 U.S.C. § 407, which provides:

> The right of any person to any future payment under this subchapter shall not be transferable or assignable, at law or in equity, and none of the moneys paid or payable or rights existing under this subchapter shall be subject to execution, levy, attachment, garnishment, or other legal process, or to the operation of any bankruptcy or insolvency law.

We disagree. A garnishment is a statutory proceeding whereby a person's property, money, or credits in possession or under control of, or owing by, another are applied to payment of the former's debt to a third person by proper statutory process against debtor and garnishee. Furthermore, the statute clearly contemplates a formal legal proceeding. Mississippi does not require that the Title II checks issued by the Social Security Administration be paid to the nursing home or anyone other than the person who is entitled to the benefits. It does not engage in formal, legal proceedings.

It seems that plaintiff's argument is that Title II benefits should be "protected income" and not counted as income in determining eligibility for Medicaid. However, Congress has specifically provided that benefits of this type *must* be considered as income in determining eligibility for and amount of benefits under the more liberal standards of the SSI program. 42 U.S.C. §§ 1382a (a)(2)(B), 1382a(b). It is clear that the Medicaid statute and regulations prohibit Mississippi from exceeding the

liberal standards of the SSI program, 42 U.S.C. § 1396a(f); 42 C.F.R. § 435.121(b)(1). Therefore, Mississippi must consider Title II payments as income.

## III. SUMMARY

We hold that Mississippi's practice of deeming the income of one spouse available to the other for Medicaid purposes, both where the spouses live together and where one spouse is institutionalized, does not conflict with the Medicaid statute or constitutional restraints.

We hold that Mississippi may promulgate general, but not rigid or arbitrary, guidelines and standards as part of a more comprehensive formulation which takes account of differing costs of living in different localities, individual necessary expenses, and the like.

We find that the state's treatment of the income of dependent children of Medicaid applicants does not constitute deeming.

We cannot see that the state's inclusion of OASDI benefits in deemed income is a garnishment.

We affirm that portion of the district court judgment which permits deeming in situations where spouses live together.

We reverse that portion which prohibited deeming in those cases where one spouse is institutionalized.

AFFIRMED in part and REVERSED in part.

APPENDIX B

# In the United States Court of Appeals
## FOR THE FIFTH CIRCUIT

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No. 77-1722

(D.C. Docket No. CA-J17-0080 cc)

NONNIE MAE NORMAN, ET. AL., PLAINTIFFS-APPELLANTS

*v.*

FRED ST. CLAIR, ET AL., DEFENDANTS-APPELLEES.

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*APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF MISSISSIPPI*

Before COLEMAN, *Chief Judge*, RONEY and FAY, *Circuit Judges*.

**JUDGMENT**

This cause came on to be heard on the transcript of the record from the United States District Court for the Southern District of Mississippi and was argued by counsel;

ON CONSIDERATION WHEREOF, it is now here ordered and adjudged by this Court that the judgment of the said District Court in this cause be, and the same is hereby, affirmed in part and reversed in part;

IT IS FURTHER ORDERED that each party is to bear its own costs on appeal.

JANUARY 28, 1980

ISSUED AS MANDATE: May 8, 1980

**APPENDIX C**

# In the United States Court of Appeals
## FOR THE FIFTH CIRCUIT

No. 77-1722 and 79-2471
(Consolidated Cases)

NONNIE MAE NORMAN, ET AL., PLAINTIFFS-APPELLANTS,

*v.*

FRED ST. CLAIR, ET AL., DEFENDANTS-APPELLEES.

MINNIE MERLI, ETC., PLAINTIFF-APPELLANT,

*v.*

FRED ST. CLAIR, ET AL., DEFENDANTS-APPELLEES

*APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF MISSISSIPPI*

**ON PETITION FOR REHEARING AND PETITION FOR REHEARING EN BANC**

(Opinion January 28, 1980, 5 Cir., 197_, ___F.2d___).
(April 30, 1980)

Before COLEMAN, RONEY and FAY, *Circuit Judges*.

PER CURIAM:

(X) The Petition for Rehearing is DENIED and no member of this panel nor Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc, (Rule 35 Federal Rules of Appellate

Procedure; Local Fifth Circuit Rule 16) the Petition for Rehearing En Banc is DENIED.

( ) The Petition for Rehearing is DENIED and the Court having been polled at the request of one of the members of the Court and a majority of the Circuit Judges who are in regular active service not having voted in favor of it, (Rule 35 Federal Rules of Appellate Procedure; Local Fifth Circuit Rule 16) the Petition for Rehearing En Banc is also DENIED.

( ) A member of the Court in active service having requested a poll on the reconsideration of this cause en banc, and a majority of the judges in active service not having voted in favor of it, rehearing en banc is DENIED.

ENTERED FOR THE COURT:

/s/ JAMES P. COLEMAN

United States Circuit Judge

April 28, 1980

## APPENDIX D

**UNITED STATES DISTRICT COURT**
**SOUTHERN DISTRICT OF MISSISSIPPI**
**JACKSON DIVISION**

CIVIL ACTION NO. J77-0080(C)

NONNIE MAE NORMAN, ET AL

*v.*

FRED ST. CLAIR, ET AL

CIVIL ACTION NO. J78-0052(C)

NELLIE WILLIAMS, ET AL

*v.*

FRED ST. CLAIR, ET AL

[Filed Apr. 26, 1979]

---

*FINAL JUDGMENT*
*ADOPTING MAGISTRATE'S ORDER*
*AS JUDGMENT OF THE COURT*

---

This cause coming on after reference to the United States Magistrate for decision based upon a stipulated record, with oral argument before the Court on March 1, 1979, and the Magistrate having heretofore entered its Opinion on April 17, 1979, and a Final Judgment in conformance with said Opinion having been signed by the United States Magistrate and filed on April 24, 1979, without objection by either party, the undersigned United States District Judge, having reviewed the proceedings conducted before the United States Magistrate, together with the findings of fact and conclusions of law and the final order filed in this cause, hereby adopts and ratifies said findings of fact and conclusions of law and final order as the final decision and judgment of this Court.

ORDERED AND ADJUDGED, this, the 26th day of April, 1979.

/s/ HAROLD COX

*United States District Judge*

## APPENDIX E

**United States District Court**
**Southern District of Mississippi**
**Jackson Division**

CIVIL ACTION NO. J77-0080(C)

NONNIE MAE NORMAN, ET AL, PLAINTIFFS

*v.*

FRED ST. CLAIR, ET AL, DEFENDANTS

CIVIL ACTION NO. J78-0052(C)

NELLIE WILLIAMS, ET AL, PLAINTIFFS

*v.*

FRED ST. CLAIR, ET AL, DEFENDANTS

**JUDGMENT**

This cause having come on to be heard on defendants' Motion to Reconsider and to Alter or Amend Judgment, and the Magistrate having considered the oral argument of counsel found that said Motion to Reconsider should be denied, and the opinion herein has been clarified by amendment as filed herein May 24, 1979.

IT IS, THEREFORE, ORDERED AND ADJUDGED that Defendants' Motion to Reconsider and to Alter or Amend Judgment be and hereby is granted in part in that the Court has amended its opinion and adopts the terms thereof in the Magistrate's Order of May 24, 1979, and the defendants have until July 1, 1979, to implement the relief directed by the Court in this cause.

ORDERED AND ADJUDGED this 19 day of June, 1979.

/s/ HAROLD COX
*United States District Judge*

A TRUE COPY, I HEREBY CERTIFY.
HARVEY G. HENDERSON, *Clerk*
BY:
/s/ J. BURTON
*Deputy Clerk*

# APPENDIX F

## UNITED STATES DISTRICT COURT
## SOUTHERN DISTRICT OF MISSISSIPPI
## JACKSON DIVISION

No. J77-0080(C)

NONNIE MAE NORMAN, ET AL

*v.*

FRED ST. CLAIR, ET AL

No. J78-0052(C)

NELLIE WILLIAMS, ET AL

*v.*

FRED ST. CLAIR, ET AL

[Filed Apr. 18, 1979]

---

## OPINION

These cases, consolidated by order of the court dated June 22, 1978, challenge the "spend-down" policy and certain "deeming" procedures used in the operation of the Medicaid program in the State of Mississippi.

### "Spend-down"

Until 1974, eligibility for Medicaid was determined by the applicant's eligibility for a state-administered general categorical assistance welfare grant (i.e. Aid to the Old Age, Aid to the Blind, Aid to the Disabled, and Aid to Families with Dependent Children). In January 1974, the Aid to the Old Age, Blind and Disabled Programs were combined in a new federally-administered program entitled the Supplemental Security Income Program (SSI).

Since a larger number of persons were eligible for SSI than were eligible for the old programs, Congress per-

mitted states the option of including in the Medicaid program only those individuals who would have been eligible for the state-administered programs on January 1, 1972, and who continued to meet that criterion, rather than using SSI eligibility as the standard for determining Medicaid eligibility. 42 U.S.C. § 1396a(f). Mississippi opted to determine Medicaid eligibility in this manner. With respect to those persons who were eligible under SSI criteria but not under 1972 criteria, Congress required that they be allowed to "spend-down" the excess of their incomes over 1972 eligibility standards by incurring medical expenses in the amount of that excess.

In Mississippi nursing home residents whose incomes are greater than $450 per month and non-nursing home residents whose incomes are greater than $175 per month (both after a disregard of $10) are not eligible for Medicaid, but can become eligible by "spending-down" [incurring medical expenses during their spend-down period—a period from one to six months, pursuant to 42 C.F.R. § 448.3(c)(4)] an amount equal to the amount their monthly income exceeds the applicable limit multiplied by the spend-down period. The spend-down period in Mississippi is six months.

Under HEW policy, the institutionalized ill, whose medical expenses are fixed and measurable and, by and large, payable to a single source, may project their expenses for the six-month period so as to become eligible for Medicaid assistance before actually incurring liability for payment of those medical expenses. The institutionalized patient must actually incur the expense—Medicaid pays only the difference between the spend-down liability and the nursing home fee—but eligibility is determined prior to establishment of liability. The non-institutionalized Medicaid recipient, on the contrary, must actually incur liability for the "spend-down" amount before becoming eligible for Medicaid assistance, despite requirements of regular medication and medical attention, the cost of which is predictible.

In 1977 the Mississippi Medicaid Commission moved to change its regulations to allow for projection of expenses

by non-institutionalized patients, but this change was vetoed by HEW and abandonned by the state.

Plaintiff Merli and members of her class contend that the distinction between institutionalized and non-institutionalized recipients on the matter of projection of expenses is irrational and in violation of the equal protection clause. Defendants assert that this distinction is founded upon a rational basis and furthers a legitimate state interest, in that the non-institutionalized patient is not subject to monitoring to determine if, in fact, he does incur the projected expenses (making improper payments by the state likely) and that such an attempt to monitor by the state would require an enormous administrative capability.

Plaintiff Minnie Merli is a non-institutionalized Medicaid recipient who suffers from rheumatoid arthritis. Her physician testified that she requires one visit per month to a physician, at $15, and medication costing $49.91 per month. In February 1978 when she sought a preliminary injunction in this cause, Mrs. Merli received OASDI benefits of $191.40. At that time the maximum monthly income in Mississippi for eligibility was $150 with a $7.50 disregard. Her spend-down was calculated as follows:

| | |
|---|---|
| $191.40 | total monthly income |
| − 7.50 | less disregard |
| 183.90 | |
| − 150.00 | less maximum allowed income |
| 33.90 | equals spend-down income per month |
| × 6 | multiplied by 6-month spend-down period |
| $203.40 | equals total Merli spend-down |

Under the Mississippi plan as set out in this calculation, Mrs. Merlie was first required to incur $203.40 per six-month period in medical bills before becoming eligible for Medicaid.

[Because Mississippi recently raised the income level and the disregard, and because of other factors, Mrs. Merli is now eligible for Medicaid without having to spend-down.]

Plaintiffs allege that a low income person such as Mrs. Merli finds difficulty in obtaining credit in such large amounts from providers of medical services and drugs. Eligibility for Medicaid then hangs upon the ability of the recipient to establish a credit line. When credit cannot be obtained from a provider, the patient may be forced to forego proper medical treatment.

The purpose of grants to states for medical assistance programs is set out in 42 U.S.C. § 1396. Such grants are to enable states

> . . . to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care . . . .

The standard of review where regulations established by the Secretary of HEW under enabling legislation are attacked has been set out in *Johnson's Professional Nursing Home v Weinberger*, 490 F.2d 841 (1974). The validity of such a regulation will be sustained so long as it is "reasonably related to the purposes of the enabling legislation". 490 F.2d at 844, quoting *Thorpe v. Housing Authority of the City of Durham*, 393 U.S. 268, 280-281, 89 S.Ct. 518, 525, 21 L.Ed.2d 474 (1968).

Both the spend-down provision in the Act, 42 U.S.C. § 1396(a)(17), and the regulations, 42 C.F.R. § 448.1, consistently speak in terms of medical expenses "incurred" by the applicant. 42 C.F.R. § 448.1(a)(ii)(B) states:

> In a state which covers only the categorically needy under its title XIX plan, and in addition has exercised its option under section 209(b) of Pub. L. 92-603 to limit Medicaid coverage of aged, blind, and disabled individuals, all individuals establishing eligibility for medical assistance by deducting their Title XVI payments (if any) and incurred medical expenses from income will be considered categorically needy regardless of whether their income would allow them to qualify for cash assistance.

Neither the Medicaid Act nor its implementing regulations specifically addresses the question of whether "incur" permits the projection of expenses. In practice, projection of expenses for nursing home recipients has been approved by HEW.

While it is true that institutionalized recipients are allowed to anticipate or project medical expenses and non-institutionalized recipients are not, defendants deny that this distinction is irrational or unreasonable. Defendants assert that in the institutional setting, expenses are rapidly incurred, easily verifiable; in the non-institutional setting they are not. The nursing home expense is fixed and unlikely to decline. Spend-down liability is likely to be reached within a matter of days or weeks. With Medicaid paying only the difference between the spend-down liability and the nursing home fee, the state can be assured that the spend-down liability has been met.

Verification of those "anticipated" expenses for a non-institutionalized patient would create an administrative nightmare. Several physicians and providers of medical assistance are often involved for each patient, and there would be no way of determining that a patient will continue to visit the doctor or conscientiously follow a prescribed course of treatment and medication. Projected expenses may thus fail to materialize.

The choices of the State of Mississippi to have a six-month spend-down period, rather than a one-month period, and to have a low level of eligibility are within the acceptable frame-work of the Act and implementing regulations. These choices obviously work a hardship on persons such as Mrs. Merli. The situation might be more appropriately attacked by seeking a change in these choices, rather than an all-out attack upon the validity of the regulations, which appear to be reasonably related to legislative purpose and not in violation of equal protection.

**"Deeming"**

Plaintiffs in these consolidated cases challenge the state's deeming policies in three different situations as il-

lustrated by three different families. The Wilsons are a Medicaid eligible couple with one spouse who is institutionalized and one spouse who lives at home. The Williams are a couple who both live at home; Mrs. Williams is potentially eligible for Medicaid, but Mr. Williams is not. The Norman case involves a Medicaid eligible husband who resides in a nursing home with a non-eligible wife residing at home with a minor child.

"Deeming" is the assumption by the state Medicaid program that a certain portion of a spouse's income (as determined by a set formula) is available for the support of the other spouse. This "deeming" of income occurs twice in the state's calculations: first, in determining Medicaid eligibility; second, in determining "Medicaid income".

Nellie Williams is aged, blind and disabled but does not reside in a nursing home. She lives with her husband, Robert, who is not aged, blind or disabled. Nellie Williams receives $40 in SSI benefits per month. Robert Williams receives $266 per month in OASDI benefits and retirement funds from the City of Greenwood. In determining whether or not Mrs. Williams is eligible for Medicaid, all of the income of the ineligible spouse in excess of $78 per month is "deemed" available for the use of the eligible spouse. Thus, $188 is considered available for the use of Nellie Williams, which with her $40 income, causes her to exceed the $175 (formerly $150) monthly income eligibility limit. The calculation is as follows:

| | |
|---|---|
| Total monthly income of Mr. Williams | $266.00 |
| Less standard deduction for living expenses of ineligible spouse | − 78.00 |
| Equals amount "deemed" available to Mrs. Williams | $188.00 |
| Plus monthly income of Mrs. Williams | + 40.00 |
| Equals total income of Mrs. Williams (In excess of $175.00) | $228.00 |

Wharey Wilson, a nursing home resident, has an income of $532 per month. Mrs. Wilson, who lives at home, has an

income of $187.50. They are both eligible for the Medicaid program. Once eligibility is determined through the same deeming process explained in the Williams case, the next step is the determination of "Medicaid Income", that is, the amount of money to be paid by the Wilsons for nursing home care out of their combined income. This amount is determined by allowance of standard deductions for personal incidentals and clothing for Mr. Wilson ($34.00), and a standard deduction for Mrs. Wilson's needs ($175.00), plus $19.54 allowed for fixed and measurable medical expenses. The resulting figure is called "Medicaid Income". The Medicaid program will pay only the difference between Mr. Wilson's actual nursing home expenses and the Medicaid Income. The calculation is as follows:

| | |
|---|---|
| Monthly income of Mr. Wilson | $532.00 |
| Monthly income of Mrs. Wilson | 187.50 |
| Total income of couple | $719.50 |
| Less allowance for Mr. Wilson | – 34.00 |
| | $685.50 |
| Less allowance for Mrs. Wilson | – 175.00 |
| | $510.50 |
| Less fixed medical expenses | – 19.54 |
| Equals Medicaid Income | $490.96 |

Troy Norman is a 79-year-old male who resides in a nursing home. His wife, Nonnie Mae, resides in the community with their son, Thomas, aged 14. Mrs. Norman is employed and earns a take-home pay of $298.26 per month. She and her son each receive monthly checks in the amount of $47.90 pursuant to Troy's Social Security disability check of $160.50 per month. Troy Norman is eligible for Medicaid, but Nonnie Mae Norman is not. In order to determine the amount Mr. and Mrs. Norman had to pay for Mr. Norman's nursing home care out of their combined income, standard deductions for personal incidentals and clothing for Mr. Norman ($34.00) and a standard deduction for Mrs. Norman's needs ($140.00) and the unmet needs of Thomas ($65.00 less his personal income of

$47.90) were made. The amount remaining after these deductions is "Medicaid Income". The calculation is as follows:

| | |
|---|---|
| Net monthly income of Mr. Norman | $153.00 |
| Net monthly income of Mrs. Norman | 346.16 |
| Total net monthly income of both | 499.16 |
| Less allowance for Mr. Norman | − 34.00 |
| | 465.16 |
| Less allowance for Mrs. Norman | − 140.00 |
| | 325.16 |
| Less allowance for unmet needs of Thomas ($65.00–47.90) | − 17.10 |
| Equals "Medicaid Income" to be paid by Normans to nursing home | $308.06 |

Plaintiffs contend that the deeming of income between spouses permitted by 42 C.F.R. § 448.3(b) is in violation of the requirements of 42 U.S.C. § 1396a(a)(17), which states:

> (a) A State plan for medical assistance must—
>
> (17) include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which . . . (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient . . ., and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child . . . .

The statute clearly states that only such income and resources as "are available" may be taken into account. This plain reading of the statute is in accord with the purpose of the statute as explained by the Senate Finance Committee, which prepared the report on the medicaid statute:

> [T]hese provisions are designed so that the States will not assume the availability of income which may not, in fact, be available . . . .

S. Rep. No. 404, 89th Cong., 1st Sess. 78, *reprinted in* [1965] U.S. Code Cong. & Ad. News 1943, 2018. Another part of this report speaks in terms of funds which are "actually available" to the recipient.

In regard to subpart (D) of the statute, the Senate report states:

> The committee believes it is proper to expect spouses to support each other and parents to be held accountable for the support of their minor children and their blind or permanently and totally disabled children even though 21 years of age or older. Scuh requirements for support may reasonably include the payment by such relative, if able, for medical care.

It appears that every court which has been presented the question has found the deeming procedure to be in violation of the Medicaid statute. The statute does not provide for taking into account income and resources which are "reasonably available" but only income and resources which *are* available. Application of an arbitrary formula which is unrelated to actual expenditures of a couple for their peculiar needs may result in the assumption by the state of the availability of income which is not, in fact, available, in violation of the statute.

The Court is of the opinion and so finds that the "spend-down" procedure employed by the state is based upon reason, common sense and practicality, and not in violation of equal protection, and on this issue finds for the defendants. The "deeming" procedure employed by the state, the Court finds, is inconsistent with the requirements of the Medicaid statute, 42 U.S.C. § 1396a(a)(17), and on this issue, finds for the plaintiffs.

An order will be prepared in accordance with this opinion and submitted to the Court within the time prescribed by the rules.

Jackson, Mississippi
April 17, 1979

/s/ JOHN R. COUNTISS, III
*United States Magistrate*

## APPENDIX G

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE SOUTHERN DISTRICT OF MISSISSIPPI**
**JACKSON DIVISION**

CIVIL ACTION NO. J77-0080 (C)

NONNIE MAE NORMAN, ET AL., PLAINTIFFS

*v.*

FRED ST. CLAIR, ET AL., DEFENDANTS

CIVIL ACTION NO. J78-0052(C)

NELLIE WILLIAMS, ET AL., PLAINTIFFS

*v.*

FRED ST. CLAIR, ET AL., DEFENDANTS

[Filed Apr. 24, 1979]

---

**FINAL JUDGMENT**

THIS CAUSE having come on for decision based upon a stipulated record, and the Court having heretofore on April 17, 1979, entered its Memorandum Opinion which contains the Court's findings of fact and conclusions of law pursuant to Rule 52(a) of the Federal Rules of Civil Procedure, it is, therefore, ORDERED AND ADJUDGED that:

1.

The Medicaid "spend-down" program for non-institutionalized recipients allows recipients with incomes greater than $175 per month (after a $10 disregard) to become eligible for Medicaid by actually accruing medical expenses during their six month spend-down period equal to the amount their monthly incomes exceed that $175 limit, multiplied by the six month spend-down period. Said program is based upon reason, common sense and practicality, and therefore is not in violation of the Medicaid statute, 42 U.S.C. Sec. 1396a, *et. seq.* or the Equal Pro-

tection Clauses of the Fourteenth and Fifth Amendments to the United States Constitution.

2.

The Medicaid statute does not provide for taking into account income and resources which are "reasonably available" but only income and resources which *are* available. Application by Defendants of their arbitrary formula which is unrelated to actual expenditures of a couple from their peculiar needs may result in the assumption by the State of the availability of income which is not, in fact, available, in violation of the statute. The State's "deeming" process therefore is declared and adjudged to be contrary to the Medicaid statute at 42 U.S.C. Sec. 1396a(a)(17) and accordingly void and unenforceable.

3.

Defendants, their successors in office, agents, employees, and all persons acting in concert with them are therefore enjoined from enforcing "deeming" practices and procedures which require that an arbitrary portion of the income of a spouse be "deemed" available to the other spouse, by use of any formula which is unrelated to actual expenditures of a couple for their particular needs, and for the needs of their children, even if said "deemed" amount yielded by the formula may in some instances seem "reasonably available." Defendants can consider in the recipient spouse's Medicaid budget only income and resources which *are* in fact available.

ORDERED AND ADJUDGED, this the 24 day of April, 1979.

/s/ JOHN R. COUNTISS, III
*United States Magistrate*

A TRUE COPY, I HEREBY CERTIFY.
HARVEY G. HENDERSON, *Clerk*

*BY:*
/s/ J. BURTON
*Deputy Clerk*

## APPENDIX H

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE SOUTHERN DISTRICT OF MISSISSIPPI**
**JACKSON DIVISION**

CIVIL ACTION NO. J77-0080 (C)

NONNIE MAE NORMAN, ET AL., PLAINTIFFS

*v.*

FRED ST. CLAIR, ET AL., DEFENDANTS

CIVIL ACTION NO. J78-0052(C)

NELLIE WILLIAMS, ET AL., PLAINTIFFS

*v.*

FRED ST. CLAIR, ET AL., DEFENDANTS

---

### AMENDMENT TO OPINION

Due to the difficulty inherent in determining the exact amount of income in fact available when spouses are living together, and one is a medicaid applicant, such as with the Williams situation, the Defendants may consider as available to the applicant all income of his or her spouse in excess of those expenses necessary for the spouse to live in the community.

The amount necessary for the spouse to live in the community shall be calculated on the basis of a reasonable and realistic estimate of the amount necessary to cover the costs of food, clothing and shelter, except that the estimate of shelter costs may vary according to the shelter costs in a particular locality. Additionally, this estimate must take into consideration the reasonable costs of necessary medical care, reasonable expenses of employment, and such other expenses as are reasonably determined by

the State to be necessary for the fulfillment of the spouse's basic living needs.

This the 24th day May 1979.

/s/ _____
*United States Magistrate*

APPROVED AS TO FORM ONLY:

/s/ DENNIS L. HORN
*Attorney for Plaintiffs*

/s/ _____
*Attorney for State Defendants*

ROBERT E. HAUBERG
*United States Attorney*

BY: /s/ L.K. TRAVIS
L.K. TRAVIS,
*Assistant Attorney for Federal Defendants*

## APPENDIX I

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE SOUTHERN DISTRICT OF MISSISSIPPI**
**JACKSON DIVISION**

---

CIVIL ACTION NO. J77-0080(C)

NONNIE MAE NORMAN, ET AL, PLAINTIFFS

*v.*

FRED ST. CLAIR, ET AL, DEFENDANTS

---

CIVIL ACTION NO.

NELLIE WILLIAMS, ET AL, PLAINTIFFS

*v.*

FRED ST. CLAIR, ET AL, DEFENDANTS

[Filed May 24, 1979]

**ORDER**

This cause having come on to be heard on defendants' Motion to Reconsider and to Alter or Amend Judgment, and the Court having considered the oral argument of counsel finds that said motion to Reconsider should be denied, but that the opinion herein will be clarified by amendment.

IT IS THEREFORE, ORDERED that Defendants' Motion to Reconsider and to Alter or Amend Judgment be and hereby is granted in part in that the Court has amended its opinion as of this date and adopted the terms thereof in this instant order and that defendants have until

July 1, 1979, to implement the relief directed by the Court in this cause.

THIS the 24th day of May, 1979.

/s/ JOHN R. COUNTISS, III
*United States Magistrate*

APPROVED AS TO FORM ONLY:

/s/ DENNIS L. HORN
*Attorney for Plaintiffs*

/s/ JIM R. BRUCE
*Attorney for State Defendants*

ROBERT E. HAUBERG
*United States Attorney*

BY: /s/ L. K. TRAVIS
L.K. TRAVIS,
*Assistant Attorney for*
*Federal Defendants*

## APPENDIX J

# In the Supreme Court of the United States

**No. A-47**

PATRICIA ROBERTS HARRIS, SECRETARY OF HEALTH & HUMAN SERVICES, PETITIONER,

*v.*

NONNIE MAE NORMAN, ET AL.

---

## ORDER EXTENDING TIME TO FILE PETITION FOR WRIT OF CERTIORARI

---

UPON CONSIDERATION of the application of counsel for petitioner,

IT IS ORDERED that the time for filing a petition for writ of certiorari in the above-entitled cause be, and the same is hereby, extended to and including Sept. 27, 1980.

/s/LEWIS F. POWELL, JR.
*Associate Justice of the Supreme Court of the United States*

Dated this 16th
day of July, 1980.

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OFFICE OF THE CLERK
SUPREME COURT, U.S.

No. 80-498

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1979

---

PATRICIA R. HARRIS, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

NONNIE MAE NORMAN, ET AL.

---

MOTION FOR LEAVE TO PROCEED IN FORMA PAUPERIS

---

Respondents Nonnie Mae Norman, Thomas Norman, Nellie Williams and Jane B. Wilson (by her next friend Marjorie Harvey) ask leave to file their Opposition to the Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit in forma pauperis pursuant to Rule 46.

In support of this motion, Respondents are filing their attached affidavits.

Respondents did not seek to proceed in forma pauperis in the courts below for the reason that the only out-of-pocket expenditures were the relatively low docket fees, which Respondents could afford. The considerably higher costs associated with filing in this Court, especially the printing costs, necessitate that Respondents

///

///

///

be permitted to file their Opposition in forma pauperis.

DATED: November 21, 1980.

DENNIS L. HORN
CENTRAL MISSISSIPPI
LEGAL SERVICES
P. O. Drawer 579
Hazlehurst, Mississippi 39083
(601) 894-1302

GILL DEFORD
NEAL S. DUDOVITZ
NATIONAL SENIOR CITIZENS
LAW CENTER
1636 West 8th Street, #201
Los Angeles, California 90017
(213) 388-1381

By Gill Deford
GILL DEFORD

Attorneys for Respondents

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1979

NO. 80-498

PATRICIA R. HARRIS, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

VS.

NONNIE MAE NORMAN, ET AL.

AFFIDAVIT IN SUPPORT OF MOTION FOR LEAVE TO PROCEED IN FORMA PAUPERIS

I, NONNIE MAE NORMAN, being first duly sworn according to law, depose and say that I am a Respondent in the above named cause, and, in support of my application for leave to proceed without being required to prepay costs or fees, state:

1. I am a citizen of the United States.

2. Because of my poverty, I am unable to pay the costs of said cause.

3. I am unable to give security for the same.

4. I believe I am entitled to the redress I seek in said cause.

5. I wish to file a Brief in Opposition to the Petition for Writ of Certiorari the Secretary of the United States Department of Health and Human Services filed herein.

Nonnie Mae Norman
NONNIE MAE NORMAN

I declare under penalty of perjury that the above and foregoing is true and correct.

EXECUTED, this the 17th day of November, 1980.

Nonnie Mae Norman
NONNIE MAE NORMAN

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1979

NO. 80-498

PATRICIA R. HARRIS, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

VS.

NONNIE MAE NORMAN, ET AL.

AFFIDAVIT IN SUPPORT OF MOTION FOR LEAVE TO PROCEED IN FORMA PAUPERIS

I, MARJORIE HARVEY, being first duly sworn according to law, depose and say that I am Mrs. Wilson's daughter and her "next friend" in the above named cause, and, in support of her application for leave to proceed without being required to prepay costs or fees, state:

1. She is a citizen of the United States.

2. Because of her poverty, she is unable to pay the costs of said cause.

3. She is unable to give security for the same.

4. I believe she is entitled to the redress she seeks in said cause.

5. On behalf of Jane B. Wilson, I wish to file a Brief in Opposition to the Petition for Writ of Certiorari the Secretary of the United States Department of Health and Human Services filed herein.

Marjorie Harvey
MARJORIE HARVEY, NEXT FRIEND OF JANE B. WILSON

I declare under penalty of perjury that the above and foregoing is true and correct.

EXECUTED, this the 12th day of November, 1980.

Marjorie Harvey
MARJORIE HARVEY, NEXT FRIEND OF JANE B. WILSON

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1979

NO. 80-498

PATRICIA R. HARRIS, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

VS.

NONNIE MAE NORMAN, ET AL.

AFFIDAVIT IN SUPPORT OF MOTION FOR LEAVE TO PROCEED IN FORMA PAUPERIS

I, NELLIE WILLIAMS, being first duly sworn according to law, depose and say that I am a Respondent in the above named cause, and, in support of my application for leave to proceed without being required to prepay costs or fees, state:

1. I am a citizen of the United States.

2. Because of my poverty, I am unable to pay the costs of said cause.

3. I am unable to give security for the same.

4. I believe I am entitled to the redress I seek in said cause.

5. I wish to file a Brief of Opposition to the Petition for Writ of Certiorari the Secretary of the United States Department of Health and Human Services filed herein.

Nellie Williams

NELLIE WILLIAMS

I declare under penalty of perjury that the above and foregoing is true and correct.

EXECUTED, this the 18 day of November, 1980.

Nellie Williams

NELLIE WILLIAMS

No. 80-498

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1979

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OFFICE OF THE CLERK
SUPREME COURT, U.S.

PATRICIA R. HARRIS, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

NONNIE MAE NORMAN, ET AL.

# BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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No. 80-498

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1979

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PATRICIA R. HARRIS, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

NONNIE MAE NORMAN, ET AL.[1/]

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## QUESTION PRESENTED

Whether the "reasonability" standard in the Medicaid statute permits participating states to use a fixed, welfare-based formula for determining how much of the income of the spouse of an applicant for Medicaid will be protected or not attributable to the spouse who is applying.

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1/ In addition to the classes described by the Secretary in her Petition, at 1 n.*, there were six named plaintiffs in the courts below who were class representatives on the claims relevant to the issue of this Petition. Of these, the following are still alive and are opposing this Petition: Nonnie Mae Norman, Thomas Norman, Nellie Williams and Jane B. Wilson (by her next friend Marjorie Harvey).

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## STATEMENT OF THE CASE

Although the Secretary's Statement (Pet., at 3-7) is essentially accurate, it neglects points relevant to the consideration of this petition.

Most important is the Secretary's failure to describe the background of the regulations which are the subject of this case. Until April 13, 1977, which was about a month after the complaint in this case was filed, the regulations applicable to the 209(b) and SSI states were exactly the same. 45 C.F.R. §248.3(b) (Oct. 1, 1976). This was so despite the fact that the SSI program came into operation on January 1, 1974. These regulations tracked the Medicaid statute, 42 U.S.C. §1396a(a)(17), by providing that "only such income and resources as are actually available will be considered and that income and resources will be reasonably evaluated." 45 C.F.R. §248.3(b)(1) (emphasis supplied). Thus, at the time that this case was filed, the applicable regulations required that all states make reasonable evaluations of income and resources, and that they not presume any income or resources available to the applicant unless they were in fact available. In practice, however, states did not follow either of these dictates, and HHS' predecessor, the Department of Health, Education and Welfare, did not require that they do so.

The revised regulations [2/] undertook for the first time to distinguish between the SSI and 209(b) states. Thus, the SSI states had their deeming policies limited by the relevant SSI provisions,[3/] while the 209(b) states were allowed to use criteria no more restrictive "than that included in the

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2/ See 42 Fed.Reg. 2684, et seq. (Jan. 13, 1977).

3/ See, generally, Herweg v. Ray, 619 F.2d 1265 (8th Cir. 1980) (en banc), pet. for cert. pending No. 80-60 (filed July 14, 1980).

State's January 1972 title XIX [Medicaid] plan." 45 C.F.R. §248.3(b)(4). Presumably, what was in a state plan on January, 1972 reflected the federal regulations then in effect, that is, those described above which required the states to make reasonable evaluations and to consider only "actually available" income and resources.[4/]

The next wording change in the regulations[5/] occurred with the rewriting and renumbering of many Medicaid regulations, effective October 1, 1978. This change resulted in the present wording of the regulation applicable to the 209(b) states, but the prologue to the "new" rules specifically stated that it created no substantive or policy changes. 43 Fed.Reg. 45176, et seq. (Sept. 29, 1979). As a result, the present regulatory citation, 42 C.F.R. §435.734, which merely restates the previous requirement that states cannot use more extensive rules than those in effect in January, 1972, represents the direct descendant of the old 45 C.F.R. §248.3(b)(1), which, under any rational interpretation, appeared to prohibit deeming altogether.

Furthermore, and perhaps most importantly, the Secretary has neglected to note that, in fact, there are no existing Medicaid deeming regulations regarding income. The regulations were invalidated over two years ago by the decision in Gray Panthers v. Secretary, Department of Health, Education

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4/ Comments to the "new" regulations primarily discuss their effect in the SSI states, corroborating the conclusion that in the 209(b) states, where only the Medicaid statute was at issue, there was no change in policy. See 42 Fed.Reg. 2684-2686.

5/ In the interim, a redesignation took place which changed the relevant regulation from 45 C.F.R. §248.3(b)(4) to 42 C.F.R. §448.3(b)(4). See 42 Fed.Reg. 52827 (Sept. 30, 1977). The wording was not altered.

& Welfare, 461 F.Supp. 319 (D.D.C.1978). Another court, in an unpublished order, also invalidated these regulations. Allen v. Califano, No. C-78-212 (D.Utah., Aug. 23, 1979), appeal pending No. 79-2167 (10th Cir.). And the District of Columbia Court of Appeals recently affirmed the invalidation of the regulations by its lower court. Gray Panthers v. Administrator, Health Care Financing Administration, No. 79-1334 (D.C.Cir., July 29, 1980), pet. for cert. pending No. 80-756 (filed Nov. 10, 1980). As a result of these decisions, and of the Secretary's inability to obtain stays from any of these courts, there have been no Medicaid regulations applicable to the deeming of income since December 8, 1978.

The Secretary's response to these decisions has been threefold. On May 18, 1979, the Department issued an "HCFA [Health Care Financing Administration] Regional Letter" to its regional offices instructing them to direct the affected jurisdictions "to cease deeming income for any length of time between aged, blind, or disabled Medicaid applicants, residing in institutions, and their spouses." It further stated that an "Action Transmittal" would follow immediately, as that "is the most expeditious way to inform States of the necessary action. The Action Transmittal will be policy, effective until revised regulations are published." Three days later the Action Transmittal was sent to the states, and it restated the order of the Regional Letter. "This Action Transmittal is therefore being issued as an interim measure to assure implementation of the[District] Court's Order in a timely manner."

Secondly, proposed regulations to implement the Gray Panthers and Allen decisions were published on November 21, 1979. 44 Fed.Reg. 66855. They were never issued in final form.

Finally, under a District Court order setting a schedule for the publication of regulations comporting with the dictates of the Court of Appeals in Gray Panthers, the Secretary published another set of proposed regulations on October 30, 1980. 45 Fed.Reg. 71821. Both of these two sets of proposed regulations, if issued finally in substantially the same form, would severely restrict state income deeming policies. The first set would have ended income deeming altogether; the second would impose time period limitations on deeming. It should be restated, however, that under the Action Transmittal of May, 1979, income deeming has been explicitly forbidden altogether. That transmittal is "policy", and is still in effect.

## REASONS FOR NOT GRANTING THE PETITION

The Secretary has offered essentially two arguments to support her petition. First, and primarily, she contends that the Court of Appeals misinterpreted the statute and that the decision below is "irreconcilable" with that of other appellate court decisions on this issue. Pet., at 7-14. Secondly, she contends that the decision below "would result in requiring the states to cover many aged, blind, or disabled individuals whom they would not have been required to cover on January 1, 1972 [a result which] conflicts with the language of 42 U.S.C. §1396a(f)." Pet., at 15. Respondents will consider each of these arguments in turn.

### 1. The 209(b) states are not subject to conflicting orders from the Courts.

As the Secretary notes, there are three other recent federal appellate decisions on the issue of deeming, all now

pending before this Court.[6/] The Secretary is a defendant in Gray Panthers, and has either filed, or intends to file, in response to invitations from this Court, an amicus brief in the other two.[7/] There is no doubt that, regardless of whether the Secretary is formally involved in a given case, HHS policies are at least somewhat at issue in all three. Not surprisingly, then, the Secretary contends that "[e]ach of these decisions is in some manner irreconcilable with the others." Pet., at 8. This analysis, however, is misleading, and does not support the granting of the petition.

First, the Herweg case has little, or nothing, in common with the other three. Iowa, the state whose policies are challenged in Herweg, is not a 209(b) state. The key to the solution of Herweg is thus not 42 U.S.C. §1396a(f), but 42 U.S.C. §1396a(a)(10). The former section permits states to use more restrictive eligibility conditions, and it is on the basis of that section that HEW and now HHS have promulgated regulations which, except for court orders and the Action Transmittal, would permit unlimited deeming in the 209(b) states. The 209(b) option, though, is the exception to the rule, which is set out in 42 U.S.C. §1396a(a)(10); in brief, it requires states to provide Medicaid coverage automatically to all the aged, blind, and disabled who are eligible for Supplemental Security Income (SSI) benefits. On the basis of this "SSI-Medicaid link", HEW promulgated the regulations which divided the SSI and 209(b) states, and required the

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6/ Gray Panthers v. Administrator, supra; Herweg v. Ray, supra; Brown v. Stanton, 617 F.2d 1224 (7th Cir. 1980), pet. for cert. pending No. 79-1690.

7/ In Brown, the government urges this Court to grant the petition. Given HHS' position before the Eighth Circuit, respondents assume that the same request will be made in Herweg.

former to limit deeming to one or six months, depending on the eligibility status of the two spouses. The comments to those regulations describe their legal basis: "The new regulations require States to use title XVI availability criteria where Medicaid is provided to all [SSI] recipients, as is already called for in section 1902(a)(10) of the [Social Security] Act [42 U.S.C. §1396a(a)(10)]." 42 Fed.Reg. 2684. The successors to those regulations, now codified at 42 C.F.R. §§435.723(c), (d) and 435.822(b), are not at issue in any of the three other cases, nor in any other pending cases.8/

Indeed, although deeming is the source of the dispute in Herweg, the real issue in that case is a larger one: whether 42 U.S.C. §1396a(a)(10) does require that the SSI states use all of the SSI criteria in their Medicaid determinations. In its regulations, and in the amicus brief filed before the Eighth Circuit, HEW, and now HHS, answer that question affirmatively. HHS supported the plaintiffs' position in Herweg, and, presumably, will do so in the amicus brief filed before this Court. The resolution of Herweg, thus, will not affect the result in this or any other pending case, or, indeed, in any conceivable case involving the criteria relevant to 209(b) states. The issue in Herweg is the relationship between the SSI program and Medicaid; that is not the issue in the case below, or in Brown or Gray Panthers. In short, it is inaccurate to characterize Herweg as irreconcilable with these other decisions. Although deeming is nominally the issue of that case as well, it bears no relationship to the other cases.

Norman, Brown, and Gray Panthers all involve the

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8/ Those regulations were implicitly upheld in the only other case challenging the deeming practices of an SSI state after those regulations became applicable. Griswold v. Page, CCH Medicare & Medicaid Guide, ¶28,537 (N.D.Fla.1977).

proper interpretation of 42 U.S.C. §§1396a(a)(17) and 1396a(f). They all are concerned with the propriety of deeming in the 209(b) states. Brown and the instant case are challenges to state practices which HHS claims are permitted under the statute. Gray Panthers is a direct challenge to the federal regulations themselves. Although there are some inconsistencies amongst the three cases, the effect of the decision in Gray Panthers is of a substantially different character than that in Brown and Norman.

If in fact the circuits have split in their analysis, it is only a philosophical, not a practical, split. The decision in Gray Panthers, since it is directed at the Secretary and requires certain policies to be implemented in all the relevant jurisdictions, automatically resolves any inconsistent decisions emanating from other circuits. At present, as has been noted, all of the affected jurisdictions are under an explicit and definitive order from HHS which forbids them from deeming. The federal regulations which are indirectly at issue in Brown and Norman are invalid, and have legally not existed for nearly two years. HHS is under orders to promulgate replacement regulations, with December 11, 1980 as the date by which those final regulations must be published. There is thus no need for this Court to intervene in the dispute because consistency among the states is guaranteed by the decision of the District of Columbia Court of Appeals.

That Gray Panthers does control the outcome, regardless of the decisions of the Fifth and Seventh Circuits, is evident from the present disposition of the cases. The Brown decision discusses the two levels of inquiry which are at issue in this kind of case. The first is the determination of the amount of income which a spouse should contribute; many states, like

Indiana and Mississippi, used to apply an arbitrary formula, such as the welfare level for that category of individual, and then deem the remaining income available. The second level of inquiry is more properly associated with the word deeming, for it is the issue of whether, regardless of how a proper amount is arrived at, a state may merely assume, or deem, that that amount is available without, in fact, the existence of an actual contribution. A necessary by-product to that question is how to treat the spouses when the "contributing" spouse fails to contribute. See 617 F.2d, at 1227-1228.

The Seventh Circuit resolved the first question in plaintiff's favor, by affirming the district court's determination that a flexible mechanism was necessary in order to ensure that the needs of the spouse and family remaining at home were met. Id., at 1228. The Fifth Circuit reached a virtually identical conclusion on this point:

> "The bottom line is that in the formulation of its applicable standards the state is not free to act arbitrarily or inflexibly but must stay within the reality of basic, fundamental facts as they apply to the status of the parties under consideration. The state may outline general guidelines for the use of local caseworkers. It must steer clear of rigid, blanket deductions to the exclusion of other factors." 610 F.2d, at 1242.

Thus, on this first level of inquiry, there is no conflict between the Fifth and Seventh Circuits. Indeed, no court which has considered the deeming issue has reached a different conclusion on this point. They agree that the statute requires, at a minimum, that a flexible system be employed to calculate the proper amount that one spouse must be permitted to keep in order to maintain the living situation. They

recognize that the use of an arbitrary and inflexible formula violates the reasonability provision of the statute. Consequently, on the issue which the Secretary asks this Court to consider, there is no conflict in the circuits.

At the second level of inquiry, the Seventh Circuit has determined that a state cannot impute a given amount available, 617 F.2d, at 1230-1231, while the Fifth Circuit allowed Mississippi to do so. 610 F.2d, at 1237. This issue, however, is not raised in the Secretary's petition. And, for all practical purposes, it has become irrelevant. First, despite the Court of Appeals' decision in Norman, Mississippi has not begun to deem again. Apparently operating according to the decision of the lower court, which precludes the consideration of income and resources which are not in fact available, CCH Medicare & Medicaid Guide, ¶29,677, at p. 10,138 (S.D.Miss.1979), and according to the HHS directives issued pursuant to Gray Panthers, Mississippi has not reverted to the other system. Furthermore, the issue will soon be moot in Mississippi, as it has decided to become an SSI state effective July, 1981, see Petition, at 14, which will require it to use the SSI-type deeming regulations.

Secondly, the precedent set in Norman cannot affect other states in the Fifth Circuit for the simple reason that Mississippi is the only 209(b) state in that Circuit. The Fifth Circuit's decision, thus, can have no direct effect outside of Mississippi.

The only difference, therefore, between the decisions in this case and in Brown is thus of no practical significance. Mississippi has not reverted to deeming, and, of course, because of the invalidation of the deeming regulations by the decisions

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in Gray Panthers, it could not.[9/] The various problems created by different circumstances have been fully considered in Gray Panthers. With those factors in mind, and with the guidance of the Court of Appeals' decision in that case, the Secretary will have to devise a flexible and rational system applicable to all deeming situations and to all affected jurisdictions. Thus, while the decisions of the Fifth and Seventh Circuits, and other courts considering the issue, provide insight and analysis, those decisions, even to the limited extent they might conflict, do not require the attention of this Court. The Norman decision will not determine how Mississippi treats the deeming issue in the future; the Gray Panthers decision will. A uniform policy has already been applied to the states via the Action Transmittal; that policy will be reinforced by new regulations issued pursuant to the Court of Appeals' decision in Gray Panthers.[10/]

The Secretary's petition is concerned with the propriety of the Fifth Circuit's requirement of flexibility, an issue on which there is no disagreement between the circuits.

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9/ Furthermore, there is no conflict between Brown and Gray Panthers. The former is focused solely on deeming between spouses separated by institutionalization. 617 F.2d, at 1226. The latter, which covers the entire range of scenarios in which deeming might arise, directs special attention at this most important area of deeming, that between spouses separated by the institutionalization of one.

10/ By contrast, if, several years from now, states apply the new regulations differently, resulting in conflicting decisions from the appellate courts, there would be a need for this Court's participation. But, at present, the issue raised by these various cases has been resolved by the invalidation of the prior regulations and the guidelines provided in the Gray Panthers appellate decision.

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Moreover, what conflict does exist between Norman, and Brown and Gray Panthers, is resolved by the far-reaching nature of the latter decision.[11/] The issue of Medicaid deeming has thus been resolved in a manner which requires a consistent policy in all the affected jurisdictions. In practical terms, there is no split in the circuits.

2. A state's use of the 1972 standard necessarily requires that that standard have been legal at that time.

The Secretary has also suggested, almost as an afterthought, that this Court should review the Fifth Circuit's determination because it will require Mississippi to employ eligibility conditions less restrictive than those in effect in January, 1972, thereby violating section 1902(f) of the Act, 42 U.S.C. §1396a(a)(17). On both legal and common sense grounds, however, the Secretary is incorrect on this point.

In both courts below, and now to this Court, the Secretary has argued that the language of the 209(b) option must be literally read to mean that whatever standards a state had in effect in January, 1972, it is permitted to employ them now. In effect, the Secretary contends that the mere failure of recipients to challenge illegal eligibility conditions in 1972 or before operates to retroactively establish their legitimacy. Thus, a state rule which was impermissible in 1972 is now permissible because it existed in 1972 and was never

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11/ Furthermore, the Norman decision stands virtually alone in its analysis on that point. As both the Norman and Brown courts noted, the district courts have uniformly concluded that deeming of any kind was not permitted under 42 U.S.C. §1396a(a)(17). See 610 F.2d, at 1240 n.16; 617 F.2d, at 1228-1230. In addition to the cases cited there, others have come to the same conclusion. Rubin v. Creasy, CCH Medicare & Medicaid Guide, ¶29,678 (S.D.Ohio 1979); Foard v. Gibson, CCH Medicare & Medicaid Guide, ¶29,679 (W.D.N.C.1979); Krygier v. Buscaglia, CCH Medicare & Medicaid Guide, ¶29,761 (W.D.N.Y.1979); Norman v. St. Clair, CCH Medicare & Medicaid Guide, ¶29,677 (S.D.Miss.1979).

invalidated. This literal reading of the provision, however, does not comport with Congress' intent, and the Fifth Circuit so recognized it:

> "[209(b)] can not be viewed as an all-purpose 'grandfathering' clause which effectively legitimizes any and every provision appearing in a state plan in 1972. We find no indication that in passing 209(b) Congress intended to authorize otherwise improper procedures. In other words, if, in January, 1972, the state's deeming procedure was impermissible under 42 U.S.C. §1396a(a)(17), it cannot now be made acceptable simply because of §209(b)." Norman v. St. Clair, supra, 610 F.2d, at 1235.

Were it otherwise, all present provisions which were in use in 1972 would be immune from challenge, regardless of the other requirements of the Medicaid statute.

This argument was also raised by the State of Illinois. The court there reached the same conclusion as did the Fifth Circuit:

> "Implicit in 42 U.S.C. §1396a(f) is the concept that any January, 1972 standard which the state might elect to return to in January, 1974, was a valid standard .... [U]pon exercising its option under 42 U.S.C. §1396a(f), [Illinois] could only elect to return to a standard which was in compliance with statutory and regulatory requirements." Winter v. Trainor, CCH Medicare & Medicaid Guide, ¶28,151 at p. 10,599 (N.D.Ill.1977); see also Caldwell v. Blum, No. 78-CV-569, Slip Op., at 21 (N.D.N.Y., Nov. 4, 1980) (re-issuance of preliminary injunction after New York took 209(b) status in response to original Caldwell decisions, 621 F.2d 491 (2d Cir. 1980)).

Courts in similar situations have reached the same conclusion: that a state cannot obtain prospective validation of illegal provisions merely because they were not invalidated in the past. See, e.g., Roselli v. Affleck, 508 F.2d 1277, 1280 (1st Cir. 1974); Johnson v. White, 528 F.2d 1228, 1236-1237 (2d Cir. 1975); Houston W.R.O. v. Chapman, 555 F.2d 1219, 1225 (5th Cir. 1977), rev'd on jur. grounds 99 S.Ct. 1905 (1979); Illinois W.R.O. v. Trainor, 438 F.Supp. 269, 279 (N.D.Ill.1977); Metcalf v. Trainor, 472 F.Supp. 576, 587 (N.D.Ill.1979). A past failure to challenge a provision cannot operate to insulate it forever from attack.[12/]

This contention is therefore without merit. No court has embraced it; every court which has been expressly faced with it has rejected it. The 209(b) option was no more than an effort to protect states from the potentially expensive costs associated with eligibility conditions based on the SSI program. See Petition, at 5. It was never intended, as the court below noted, as an "all-purpose 'grandfathering' clause." 610 F.2d, at 1235.

## CONCLUSION

There is no split in the circuits on the arguments raised by the Secretary. Even if there were, all aspects of this issue have been resolved by the decision in Gray Panthers. Whatever differences may exist in the various cases, the decision of the Court of Appeals for the District of Columbia Circuit provides consistent direction for the Secretary

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12/ Indeed, necessarily implicit in all decisions upholding challenges to eligibility conditions in 209(b) states is that the Secretary's interpretation of §209(b) is wrong. Were it otherwise, these decisions would have had to have gone the other way, for they were brought on the same basis as was this case, i.e., that a provision now in effect was invalid in both 1972 and the present.

and the states.

The petition for certiorari should therefore be denied.

DATED: November 21, 1980.

Respectfully submitted,

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OCTOBER TERM, 1980

PATRICIA ROBERTS HARRIS, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER,

v.

NONNIE MAE NORMAN, ET AL., RESPONDENTS

CERTIFICATE OF SERVICE

I, Gill Deford, a member of the Bar of the Supreme Court, do hereby certify that, pursuant to Rule 28.5 of the Rules of this Court, I have served on this 21st day of November, 1980, three copies of the MOTION FOR LEAVE TO PROCEED IN FORMA PAUPERIS by depositing them, enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Mail at Los Angeles, California, addressed to WADE H. McCREE, JR., Solicitor General, ALICE DANIEL, Assistant Attorney General, GEORGE W. JONES, Assistant to the Solicitor General, Department of Justice, Washington, D.C. 20530; and to JOAN Z. BERNSTEIN, General Counsel, ROBERT P. JAYE, EDITH S. MARSHALL, DAVID SMITH, Attorneys, Department of Health and Human Services, Washington, D.C. 20202.

I further certify that all parties required to be served have been served.

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